Migration and Health in the UK

an ippr FactFile

February 2005

Institute for Public Policy Research
30–32 Southampton Street, London WC2E 7RA, United Kingdom
Registered Charity No 80006

ippr *FactFiles* on Asylum and Migration

Immigration and asylum issues are currently high on the political and public agenda in the UK as reflected by recent opinion polls. Despite this, there is very little objective and easily accessible information about the key issues and facts informing these opinions. The information that exists is often very complex, sometimes difficult to disaggregate and increasingly provided by organisations with particular concerns or interests. In many ways the asylum and immigration debate has become polarised, between those on the one hand who believe that the impact of immigration is overwhelmingly negative and should therefore be limited, and those on the other who are concerned about the rights of migrants and with ensuring that the benefits of migration are understood and facilitated by Government policy. This debate is characterised by a tendency to use information about asylum and immigration in a selective and partial way or taken out of context.

One of the key objectives of ippr's Migration Programme is to engage the media and the public in an informed and evidence-based debate. As part of this process we are consolidating the available evidence on asylum and immigration issues in the form of accessible *FactFiles*. Three of these documents have already been produced; **Asylum in the UK, Labour migration** and **EU enlargement and labour migration** are available on the ippr website.

The impact of migration on health is particularly relevant to the wider debate about the value and viability of managed labour migration and the nature of the asylum system in the UK. Previous *FactFiles* have attempted to clarify and disaggregate issues of asylum and migration that are often mistakenly conflated. The purpose of this document is to elucidate how migration impacts upon health in the UK in terms of employment and treatment. There is increasing interest in the role migrants play in the running of the National Health Service (NHS) as well as the rights migrants obtain to benefit from the NHS. The empirical evidence presented here can inform a more constructive and comprehensive discussion of the issues and facilitate a move beyond a debate based around rhetoric and vested interest.

This *FactFile* has been prepared by **Rachel Kelly**, **Gareth Morrell** and **Dhananjayan Sriskandarajah**.

For more information about the Migration Programme please visit our website at www.ippr.org/migration or contact:

Francesca Hopwood Road
Institute for Public Policy Research
30-32 Southampton Street
London
WC2E 7RA
020 7470 6148
f.hopwood@ippr.org

Contents

What contribution do migrants make to the NHS?

In recent years, the NHS has increasingly struggled to fill vacant posts with staff trained in the UK. Although various steps have been taken to address this problem, such as recruiting migrant workers and increasing medical school capacity, the UK still needs some 10,000 additional doctors (Dobson 2004). There are particular shortages in certain geographical regions or localities as well as in specific specialties. The London region has been acutely affected given the diverse nature of the region, making it difficult to recruit staff for the less popular areas, usually those more socially and economically deprived (Woodhead *et al*. 2002). Similarly, staff trained abroad are disproportionately represented at consultant level in specialties that are difficult to fill (Goldacre *et al*. 2004).

Migrant workers have increasingly been recruited to fill these gaps and the migration of health professionals to industrialised countries is predicted to increase in the coming years (Bach 2003). Migrant health personnel have provided an important means to meet staff shortages and to reduce cost pressures within the health system. Migrants now make a considerable contribution to the running of the UK's healthcare system. This is true not only for doctors and nurses but also for workers involved in the day to day running of Britain's hospitals and specialists bringing valuable skills to the NHS. It is for this reason that the contribution that migrant healthcare workers make to the UK's health system is often cited when making a positive case for labour migration.

There is no systematic collation of data on the total number of foreign workers in the NHS due to disparities in collection and incongruities across departments and districts (Woodhead *et al*.). There are several statistical bodies, however, that can help approach this issue and try to grasp and develop a more coherent empirical picture of the situation on the UK. The NHS workforce statistics and medical registers of the General Medical Council (GMC) and Nursing and Midwifery Council (NMC) allow us to present the issue more accurately. What is not recorded for doctors is the specific nationality of all health workers, so we use the place of qualification, assuming that largely it will be the same as the country of birth, to estimate the contribution of migrants to the NHS. For nurses, the NMC require all professionals from abroad to be admitted to their register before practicing – the country from which they are admitted is recorded. It is worth noting that all health professionals are required to register their qualifications with the GMC and the Health Professionals Council.

How many migrants work in the NHS?

1. Doctors

Hospital practice in the NHS has become increasingly dependent on doctors recruited from outside the UK (Goldacre *et al*. 2004); in 2003, nearly a third (29.4 per cent) of doctors working in the NHS obtained their qualification overseas (see Table 1). Doctors who had qualified outside the European Economic Area (EEA) made up one quarter (24.5 per cent) of all NHS doctors in 2003 having accounted for less than one fifth in 1993. This increase made up a significant proportion (38.6 per cent) in the overall growth in doctor numbers in the NHS over the last decade. The proportion of doctors trained in the UK fell by 4.9 percentage points at the same time as the proportion of doctors from outside the EEA increased by the same amount of percentage points. This trend shows signs of continuing as figures recently released show that UK foreign medical graduates trained outside the EEA make up some 65 per cent of staff grades; this figure falls to 17 per cent for consultants (Dobson 2004).

Table 1: All NHS doctors by country of medical qualification, 1993 and 2003

Place of Qualification	1993		2003			
	Number	*% of Total*	Number	*% of Total*	% Change	*Change in Share*
UK	58,106	*72.0%*	73,134	*67.1%*	25.9%	*-4.9%*
EEA	3,334	*4.1%*	5,343	*4.9%*	60.3%	*0.8%*
Elsewhere	15,836	*19.6%*	26,753	*24.5%*	68.9%	*4.9%*
Non-UK Total	19,170	*23.7%*	32,096	*29.4%*	67.4%	*5.7%*
Unknown	3,462	*4.3%*	3,763	*3.5%*	8.7%	*-0.8%*
Total	**80,738**	***100.0%***	**108,993**	***100.0%***	**35.0%**	

Source: Figures quoted by Department of Health medical and dental workforce census and Department of Health General and Personal Medical Services Statistics, 2003

The trends clearly show that the NHS has increasingly recruited from outside the UK to rectify staffing shortages. Almost one in three NHS employees received their qualifications overseas. Such a trend is not indicative of the role of migrant workers on the economy at large; table 2 shows the proportion of migrants and migrant workers as a percentage of the total UK population.

Table 2: Migrants in the UK, 1993 and 2003

Place of Qualification	1993		2003		
	Number	*% of Total*	Number	*% of Total*	% Change
All Migrants	2,001,000	*3.5%*	2,865,000	*4.8%*	43.2%
Migrants Workers	862,000	*3.4%*	1,396,000	*4.9%*	61.9%

Source: Labour force survey data, see OECD (2003: Table A.1.5 and Table A.2.3) and Salt (2003: Table 4.3).

Even if we assume that half of the migrant workers in the NHS who received their qualifications abroad are also foreign nationals, the proportion of foreign doctors in the NHS would be more than double the proportion of foreign workers in the wider economy (4.9 per cent in 2003). Furthermore, while it is true that the number of foreign workers has increased dramatically in the last decade (61.9 per cent), the growth in migrant health workers has been even greater (67.4 per cent). This is particularly significant given that health workers already accounted for a much greater proportion of all migrant workers (1.8 per cent) than did domestic health workers of total working population (0.2 per cent).

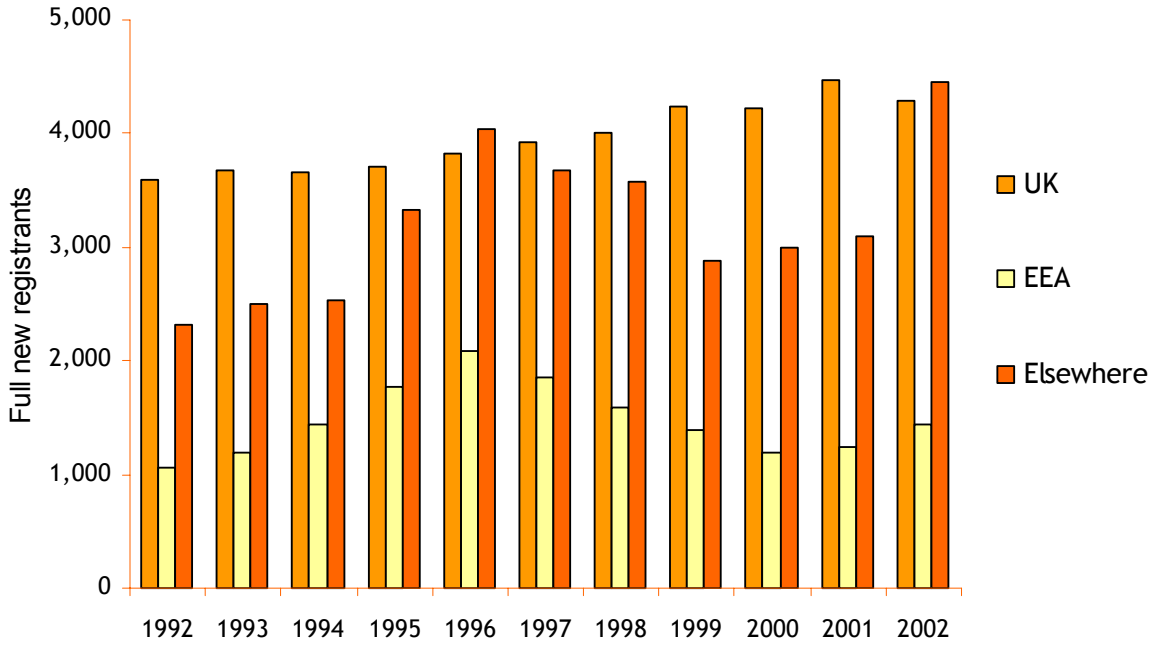
Table 3: Place of qualification for full new registrants, 1992–2002

Year	UK		EEA		Elsewhere	
	Number	*% of Total*	Number	*% of Total*	Number	*% of Total*
1992	3,586	*51.6%*	1,054	*15.2%*	2,312	*33.3%*
1993	3,675	*49.9%*	1,188	*16.1%*	2,500	*34.0%*
1994	3,657	*47.9%*	1,444	*18.9%*	2,539	*33.2%*
1995	3,710	*42.1%*	1,779	*20.2%*	3,327	*37.7%*
1996	3,822	*38.4%*	2,084	*20.9%*	4,047	*40.7%*
1997	3,920	*41.4%*	1,860	*19.7%*	3,678	*38.9%*
1998	4,010	*43.7%*	1,590	*17.3%*	3,580	*39.0%*
1999	4,242	*49.8%*	1,392	*16.3%*	2,889	*33.9%*
2000	4,214	*50.2%*	1,192	*14.2%*	2,993	*35.6%*
2001	4,462	*50.8%*	1,237	*14.1%*	3,088	*35.1%*
2002	4,288	*42.1%*	1,448	*14.2%*	4,456	*43.7%*
Total	**43,586**	***45.8%***	**16,268**	***17.1%***	**35,409**	***37.2%***

Source: GMC data. See GMC Annual Report and Accounts 2002 (2002: p.5) http://www.gmc-uk.org/download/report2003.pdf and the Medical Register Statistics (1998: p. XXV) http://www.gmc-uk.org/register/stats/MedRegStats1998.pdf

Table 3 shows annual registration figures for new doctors in recent years from the GMC. This provides further evidence that overseas qualified doctors have made up a significant contribution to the UK's healthcare workforce, particularly recently. All doctors wishing to practice medicine in the UK must be registered with the GMC. In the decade up to 2002, more than half (54.2 per cent) of new registrations were doctors whose primary qualification had been obtained outside of the UK. Although the figures do not specify the nationality of new registrants, it would be safe to surmise that the majority of new doctors in the UK are migrants (rather than UK nationals who went overseas to obtain their qualification).

Figure 1: Place of qualification for full new registrants, 1992-2002



Source: GMC data. See GMC Annual Report and Accounts 2002 (2002: p.5) http://www.gmc-uk.org/download/report2003.pdf and the Medical Register Statistics (1998: p. XXV) http://www.gmc-uk.org/register/stats/MedRegStats1998.pdf

An equally significant development has been the increasing proportion of migrant health workers accounted for from outside the EEA; in fact, in 1996 and 2002 there were more full new registrants from non-EEA countries alone than from the UK. It is clear that the NHS is vastly dependent upon migrant workers and will continue to be in order to maintain adequate staffing levels.

2. Nurses

The NHS does not collect specific data on where nurses obtained their qualification, though any nurse who wishes to practice in the UK must be registered with the Nursing and Midwifery Council (NMC), which is the professional regulatory body. It is from these figures that we are able to deduce what contribution migrant nurses make

to the NHS. The NMC estimate that the number of nurses and midwives on the register who trained overseas at 65,000, around 10 per cent of the total number registered.[1]

Trends would suggest that this figure is likely to increase. Since 1999, 43.5 per cent of admissions to the NMC register have been from outside the UK (see Table 4). This is substantially greater than the estimated 10 per cent of total nurses and midwives who are foreign nationals. If we continue to see figures similar to those of the last five years, then the overall proportion of foreign born nurses is likely to increase.

Table 4: Initial admissions to the NMC council register, 1999-2004

Year	UK		EEA			Elsewhere		
	Number	*% of Total*	Number	*% of Total*	*% of non-UK*	Number	*% of Total*	*% of non-UK*
1999/2000	14,035	*65.6%*	1,416	*6.6%*	19.2%	5,945	*27.8%*	80.8%
2000/2001	15,433	*61.4%*	1,295	*5.2%*	13.4%	8,403	*33.4%*	86.6%
2001/2002	13,538	*45.6%*	1,091	*3.7%*	6.8%	15,064	*50.7%*	93.2%
2002/2003	18,216	*57.4%*	802	*2.5%*	5.9%	12,730	*40.1%*	94.1%
2003/2004	19,465	*56.2%*	1,030	*3.0%*	6.8%	14,122	*40.8%*	93.2%
Total	**80,687**	***61.5%***	**5,634**	***4.3%***	**9.1%**	**56,264**	***39.5%***	**90.9%**

Source: NMC Statistics, unpublished, http://www.nmc-uk.org/nmc/main/publications/Annualstatistics2002_2003.pdf p. 9

Table 4 shows the increasing significance of migrant workers in filling nursing positions. The proportion of non-UK nurses has, since 1999, been consistently between 33 per cent and 55 per cent, yet the most striking feature of the table is the increase the number of nurses admitted to the register from outside the EEA; this is particularly significant given that it is easier for nurses qualified within the EU to be admitted to the NMC register in the UK as a result of the mutual recognition of qualifications. Despite this potential barrier to nurses from outside the EEA, over the five-year period 1999-2004 they accounted for more than 90 per cent of all nurses from outside the UK admitted to the NMC register; this grew from accounting for 80.8 per cent in 1999 to 93.2 per cent in 2004.

The increase in the recruitment of nurses from abroad has two possible explanations: demand for nurses increased above the domestic supply or the domestic supply contracted. Department of Health statistics indicates that the number of nurses employed by the NHS increased by an average of 1.9 per cent per annum between 1993 and 2003 (NHS 2003); this is despite a decrease in the number of training places available for nursing and midwifery in the UK from 1992-1997 (Parliamentary question 2004). This suggests that migrant health workers, along with a number of other

[1] From private correspondence with the NMC

factors were making a contribution in accounting for both an increase in demand and a fall in the domestic supply of nurses.

The contraction in supply of the domestic nursing workforce is not just a result of a decrease in training places. The NMC also provides statistics on British-trained nurses who choose to work abroad by recording the requests for verification of qualifications of these individuals they receive from equivalent overseas regulatory bodies. From 1998-2003, the NMC registered 45,763 nurses from abroad and received 27,904 requests, equalling a net inflow of nurses of 17,832. This means that migrant nurses are also compensating for nurses trained in the UK moving abroad.

Table 5: Initial admission to the NMC register by country, 1998-2003

Country of Origin	1998/99	1999/00	2000/01	2001/02	2002/03
Philippines	52	1,052	3,396	7,235	5,593
India	30	96	289	994	1,830
South Africa	599	1,460	1,086	2,114	1,368
Australia	1,335	1,209	1,046	1,342	920
Nigeria	179	208	347	432	509
Zimbabwe	52	221	382	473	485
New Zealand	527	461	393	443	282
Ghana	40	74	140	195	251
West Indies	221	425	261	248	208
Pakistan	3	13	44	207	172
Other	583	726	1,019	1,381	1,112

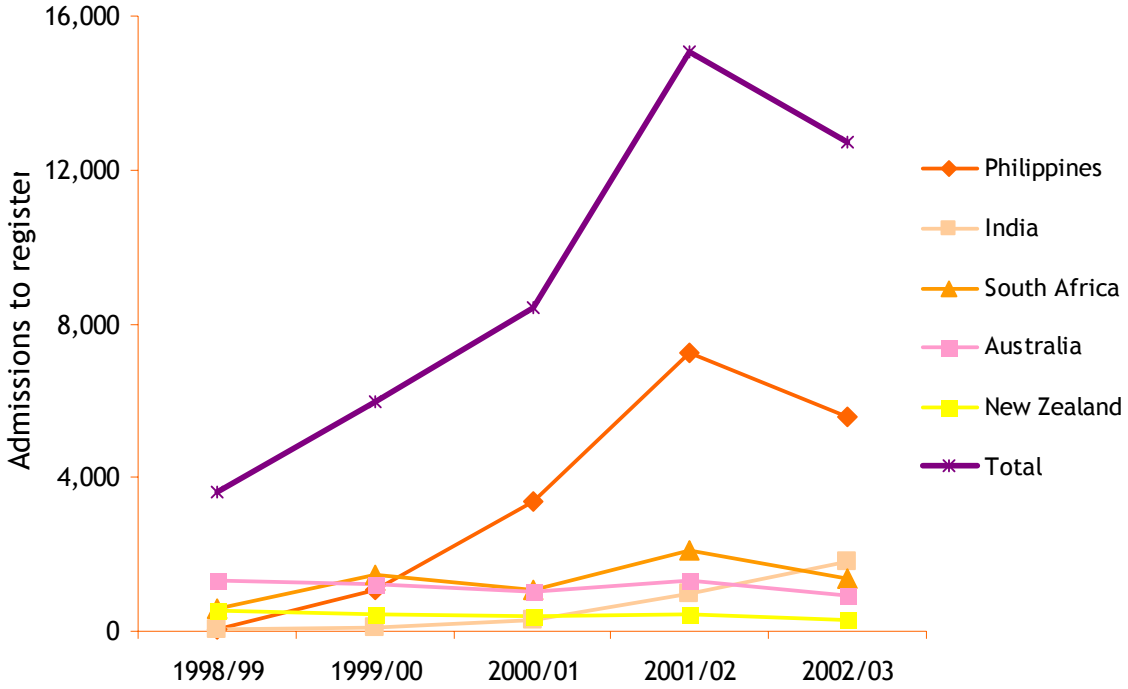
Source: NMC Statistical Analysis of the register 2004
http://www.nmc-uk.org/nmc/main/publications/Annualstatistics2002_2003.pdf pp9
Note: The drop in numbers of overseas admissions to the NMC register in the year 2002 to 2003 is reflective in an administrative backlog and not a decrease in applications to come to work in the UK.

Table 5 depicts the top ten countries from which nurses and midwives were recruited by the NHS from 1998 to 2003. Not included in this chart are those trained inside the EEA. In 1998/99, over half (68 per cent) of all foreign admissions were recruited from the more developed Commonwealth countries of Australia, New Zealand and South Africa. In absolute terms, despite some fluctuations, the number of admissions from these countries has stayed fairly steady at around 3,000, rising slightly as a result of a large increase in admissions from South Africa and a smaller fall in admissions from the Australasian nations. In relative terms, however, the proportion of admissions from these countries has dropped substantially from 68 per cent in 1998/99 to 20.3 per cent in 2002/03.

This can be almost entirely explained by the considerable increase in the number of admissions from the Philippines; in 1998/99 the Philippines accounted for merely 1.4

per cent of total admissions with just 52 nurses making the journey. By 2002/3 the number of admissions from the Philippines was 5,593 (and 7,235 for the previous year) and accounted for 43.9 per cent of all overseas admissions. If India's figures are added to this, then the fall in the proportion of admissions from Australasia and South Africa is more than accounted for: admissions from India increased from 30 in 1998/99 to 1,830 in 2002/03. By 2003, the Philippines and India accounted for more than half (58.3 per cent) of all foreign admissions to the NMC register and had replaced Australia and South Africa as the largest suppliers of nursing staff to the NMC register. Figure 2 illustrates these changing dynamics more clearly. The correlation between the Philippines' line and that of the total number of admissions highlights the large impact of admissions from that country on overall levels of admissions from abroad.

Figure 2: Initial admission to the NMC register, selected countries, 1998-2003



Source: NMC Statistical Analysis of the register 2004
http://www.nmc-uk.org/nmc/main/publications/Annualstatistics2002_2003.pdf p. 9

This exponential rise in the number of admissions from the Philippines has taken place despite government initiatives to stem the flow of nurses to the UK from countries that are themselves experiencing staffing shortages or from developing countries more generally (Department of Health 2001). The negative effect such movements of skilled migrants may have in the sending countries will be discussed below, yet the contribution these migrants are making to the NHS is unequivocal.

3. Dentists

The figures for dentists paint a similar picture to those for doctors and nurses. There has been renewed speculation in the national press about a shortage of NHS dentists and continuing controversy over the increasing tendency for NHS practices to become

private (BBC News 2004*b*). Regardless of the adequacy of absolute numbers of dentists, the dependence of this total upon dentists who have qualified abroad is significant. In 2003, the number of dentists registered on the General Dental Council's (GDC) register that obtained their qualifications overseas was over 5,000; this accounted for 17 per cent of the total register.

Table 6 below shows the breakdown of new admissions to the GDC's register in the last few years by where their qualification was obtained. A growing number of those on the register have obtained their qualifications abroad. In 2001, 37 per cent of the new admissions obtained their qualifications from abroad; by 2003 this figure was above 40 per cent. The proportion of new admissions from abroad is far greater than the overall proportion of foreign dentists, which suggests that the importance of migrant health workers to the dental profession is likely to increase.

Table 6: New admissions to GDC register by year and place of qualification, 2001-2003

	2001		2002		2003	
Place of Qualification	Number	*% of Total*	Number	*% of Total*	Number	*% of Total*
UK	849	*63%*	784	*59%*	791	*59%*
EEA	276	*20%*	266	*20%*	268	*20%*
Elsewhere	173	*13%*	239	*18%*	241	*18%*
IQE	59	*4%*	40	*3%*	40	*3%*
Non-UK Total	508	*37%*	544	*41%*	549	*41%*
Total	**1,357**	**100.0%**	**1,328**	**100.0%**	**1,340**	**100.0%**

Source: GDC Annual Reports, available at http://www.gdc-uk.org/publications.html
Note: IQE means international qualifying examination, provided overseas by the GDC

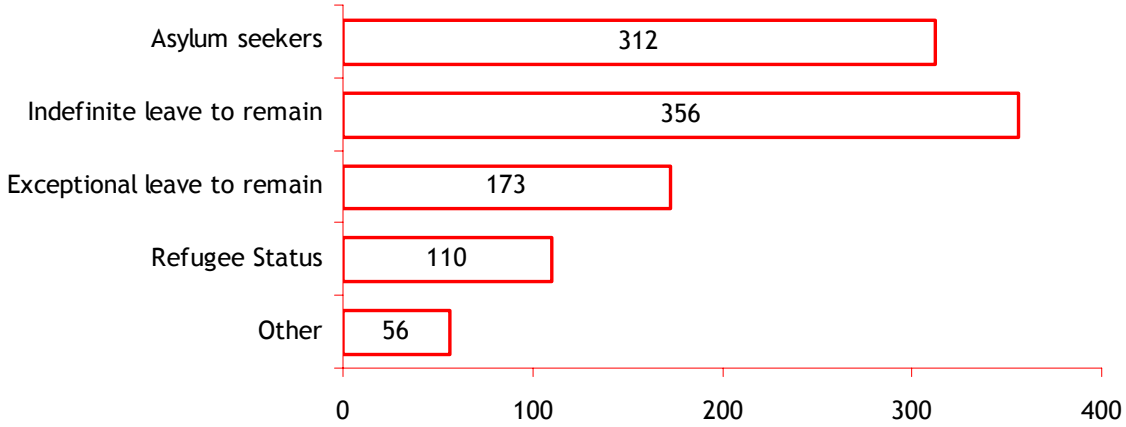
The striking difference amongst migrant workers in the dentistry profession is the greater significance of those from the EEA. Doctors and nurses from overseas are largely recruited from outside the EEA, as the above sections highlight. In dentistry, however, 20 per cent of the new admissions to the GDC register in the last three years have been from those qualified within the EEA, which represents more than half of the total of dentists with overseas qualifications. The significance of people qualified outside the EEA is increasing, but this has been at the expense of British-trained dentists rather than those from within the EEA.

4. Refugees

A number of asylum seekers and refugees have arrived in Britain with medical experience and qualifications; Figure 3 depicts the immigration status of the 1,007 doctors currently registered on the BMA/Refugee council list. Most of these doctors

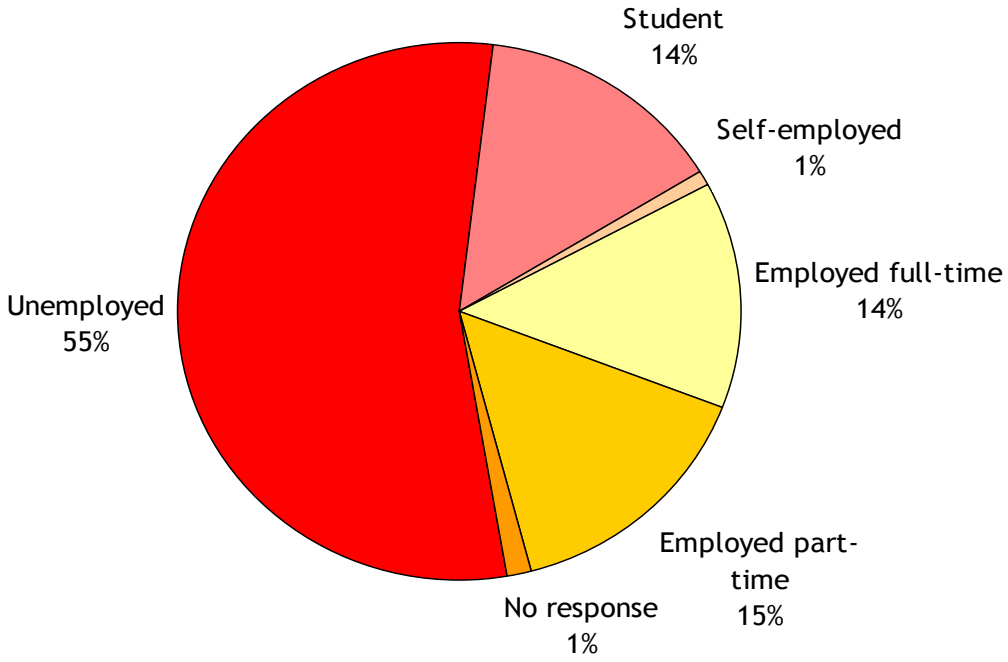
are either ineligible to work in the UK or have problems with the recognition of qualifications (BMA 2004). Of the few who are employed in the NHS, many are required to work at a lower level until their qualifications are verified or they have been retrained. The survey also provides information on the origin of these doctors. Unsurprisingly, over half are from countries currently or recently ravaged by war and conflict (53 per cent from Iraq, Afghanistan, Sudan and Somali Republic).

Figure 3: Immigration status of refugee and asylum seeking doctors, December 2004



Source: BMA statistics, December 2 2004, http://www.bma.org.uk/ap.nsf/Content/Refugeedoctorstats

Figure 4: Employment status of refugees with nursing qualifications and permission to work in the UK, 2004



Source: RCN Refugee Nurse Database Report, December 2004, http://www.rcn.org.uk/news/refugeenurses.php

The tendency of refugee doctors to be underemployed is replicated when we view the statistics for refugee nurses (figure 4). There are currently 229 nurses registered on the Refugee Nurse database, of which 148 have permission to work in the UK. However, 55 per cent of those allowed to work are unemployed, with a further 15 per cent only able to obtain part-time work, augmenting the underemployment of refugee nurses.

The statistics on refugee doctors and nurses are likely to be underestimates given that the databases are voluntarily entered into. The problem of underemployment is, therefore, likely to be more severe even than these figures suggest. Taking into account the demand that exists for migrant health workers within the NHS, these figures may be surprising, yet there are a number of obstacles that refugee health workers are confronted with when seeking employment (Bloch, ippr 2004):

- *Language barriers*: affect completing applications and performing in interviews and are considered the single largest obstacle to employment for refugees.
- *Recognition of qualifications*: it is unlikely that the qualifications obtained in their country of origin will be recognised in the UK.
- *Training Provision*: as suggested by the above figures on refugee doctors, only a small proportion of those who need to re-train or qualify to UK standards actually receive the training they need.
- *Discrimination*: despite the large numbers of non-UK trained medical staff now working for the NHS, discrimination still exists in the employment of migrant health workers and this is likely to be more acute for those tarnished by the stigma attached to asylum seekers and refugees (BMJ editorial 2004).

These obstacles to employment leave many refugees on benefits or working in menial jobs, sometimes in the NHS as mentioned above, for which they are greatly overqualified (BMA 2004). This is not only an underemployment of resources but also further marginalises the position of many asylum seekers and refugees, and can negatively affect the public perception of these groups. It is clear that more needs to be done to improve employment opportunities for refugees, particularly where there are valuable skills to be utilised, such as the health sector (see Bloch, ippr 2004).

5. Skills

Migrant health workers can bring specific skills to the UK that may be lacking within the domestically-trained workforce. Table 7 details the top ten specialities, by numbers employed, of trained doctors in the NHS. To be eligible for these positions an individual would require additional training on top of primary medical education. Migrant health workers account for more than one third of all doctors employed in the top ten NHS specialities; in five of these specialities more than 40 per cent of doctors are migrants.

This information indicates that migrant health workers in the UK are recruited as a result of shortages in the domestically trained workforces for specialists. The top ten NHS specialities are significantly dependent upon migrant health workers and the NHS clearly saves vast resources by recruiting staff that have been trained abroad. The

proportion of migrant doctors working in these specialties is higher than the proportion of migrant employed throughout the NHS as a whole.

Table 7: NHS staff (England) for top ten specialities (by staff numbers) by place of primary qualification, 2003

Specialism	All Doctors	UK		Non-UK	
		Number	*% of Total*	Number	*% of Total*
Opthalmology	2,201	1,243	*56.5%*	958	*43.5%*
Clinical Radiology	2,693	2,046	*76.0%*	647	*24.0%*
Geriatric Medicine	2,848	1,848	*64.9%*	1,000	*35.1%*
Accident and Emergency	3,607	2,450	*67.9%*	1,157	*32.1%*
Trauma and Orthopaedic Surgery	4,346	2,527	*58.1%*	1,819	*41.9%*
Obstetrics and Gynaecology	4,448	2,345	*52.7%*	2,103	*47.3%*
General Psychiatry	5,076	2,670	*52.6%*	2,406	*47.4%*
General Surgery	5,628	3,905	*69.4%*	1,723	*30.6%*
Paediatrics	5,850	3,414	*58.4%*	2,436	*41.6%*
Anaesthetics (inc. intensive care)	8,747	5,710	*65.3%*	3,037	*34.7%*
Total	**45,444**	**28,158**	***62.0%***	**17,286**	***38.0%***

Source: Department of Health medical and dental workforce census, 2003, http://www.publications.doh.gov.uk STATS/d_results.htm

Is there a 'brain drain' effect for developing countries?

All the evidence above clearly shows the contribution that migrant health workers make to the functioning of the NHS and, that this contribution is likely to grow as the health service continues to expand. Yet what is the impact of this process on the countries that lose these skilled workers? There are implications for the equity, quality and availability of health services in the source countries from which migrant health workers are arriving (World Health Organisation (WHO) 2002; Lowell *et al*. 2004). Despite benefits for both the source and recipient country, substantial and sustained emigration of highly-skilled workers from some sectors in some countries can lead to critical shortages of some skills and undermine the ability of some countries to deliver certain public goods (like healthcare). Moreover, when a developing country loses personnel whose training has been funded from the public purse, there may be significant financial implications:

- India has reportedly lost up to $5bn in investment of training of doctors since 1951, which is reflected in the fact that 12 per cent of India's doctors are currently working in the UK (Lowell *et al*. 2004);
- Ghana has lost around $60m in investment and training of health workers in the same time period (WHO 2002).

The UK government has, however, recognised the strain that this inevitably places on the source countries and has implemented policies aimed at reducing the impact. For example, in 1999 the Department of Health placed a ban on the NHS recruiting from countries where there is a shortage of nurses. The Department of Health also has a Code of Practice (2001) and guidelines on the international recruitment of consultants and GPs (Lowell *et al*. 2004). It is also widely acknowledged that the UK has been very pro-active in developing guidelines and in doing so is consistently setting the agenda in relation to good practice. However, there is more to be done to ensure that highly skilled migration is optimised for both developed and developing countries.

What are the major health issues associated with international migration?

Migration exposes the individual to a number of health risks that can affect the migrant as well as both sending and receiving societies. There are health issues specific to all migrants and migration processes, but also issues specific to certain groups of migrants:

1. All migrants

While migrants are an extremely diverse group, the majority are relatively young and have satisfactory health status on arrival. In fact, most newcomers to a country are healthier than the host population and, indeed, this good health can often deteriorate after they arrive at their destination and begin living in a new society (Williams 1993).

This tendency is explained by a number of factors, not least the difficulties migrants confront dealing with health problems in a new society. Many migrants have formally restricted access to health services and health insurance in host countries (see table 7). Furthermore, migrants often face informal obstacles to treatment by not being fully aware of their rights to use medical resources; language can also be a barrier to migrants receiving all the health care they are eligible for. Migrants, therefore, often under-employ the health services legitimately available to them.

The mental and psychological health of migrants can also be affected by the process of migration. The stress of leaving a country and family behind, perhaps embarking on a long journey and arriving in a foreign society can have a negative affect on health. This can be further compounded by discrimination and marginalisation upon arrival in the destination country. Migrants can consequently suffer from feelings of insecurity and reduced socio-economic status, particularly in terms of formal and informal access to housing, jobs and education.

2. Refugees

Refugees face all the problems detailed in the previous section, but often also face problems specific to being a refugee. Apart from the mental and psychological effects of fleeing from persecution, they can also be vulnerable to health risks, given the more stuttering and informal nature of their migration experience.

Health care is not always the first priority for refugees and asylum seekers in comparison with the need for accommodation, employment and education; an understandable preoccupation with these issues on arrival can delay contact with the health system (Clinton-Davis *et al*. 1992). In this respect, health problems of refugees overlap with those problems faced by other deprived or marginalised groups, such as those on benefits or with low incomes. Asylum seekers survive on benefits that are less than income support (NASS 2004) and are often forced to live below the 'poverty line'. This absolute dependence can itself be a cause of mental and psychological health problems.

There are also a number of problems that specifically affect the health of refugees as a result of the nature of this form of migration:

- By default, refugees who have faced persecution of whatever kind are unlikely to have received good quality, if any, health care before leaving their home country.
- Those who have travelled through numerous refugee camps will have been exposed to higher risks of communicable disease, nutritional problems and poor sanitation (Sinnerbank *et al*. 1997).
- As a result of the drawn-out process of seeking asylum, but also of the likelihood that a refugees country of origin may be in conflict or social turmoil, it is unlikely that many will have medical records that are intact or retrievable Aldous *et al*. 1999), which can lead to inappropriate treatment (Burnett and Peel 2001).
- There often psychological effects, as well as the physical effects, that asylum seekers face as a result of severe shock and trauma of torture or discrimination; a Home Office survey shows that 16 per cent of those seeking asylum in the UK were suffering from physical health problems and two thirds reported feelings of anxiety and depression (Home Office Research and Statistics Department 1995).
- Current worries for refugees about problems of adapting to the new society seem to be a stronger factor for psychological stress than previous exposure to violence and conflict (Centre for the Advancement of Health 2000; Sundquist *et al*. 2000).
- Asylum seekers awaiting a decision are under particular stress given that placing them into detention centres largely reproduces feelings of discrimination, marginalisation and maltreatment the detainees are seeking refuge from (Jones and Gill 1998). Furthermore, the dispersal of refugees to already deprived areas that have had little exposure to ethnic minority communities and where there are not appropriate services exacerbates the problem.

These problems are summarised and categorised below (Table 8) into factors originating in the home country and those to which migrants are exposed when they arrive at their destination. It is important to note that asylum seekers also face problems specific to the nature of their migratory experience such as the refugee camps that they are housed in; these have been alluded to above and health problems arising from treacherous journeys overlaps with the following section.

Table 8: Summary of health problems suffered by asylum seekers

Problems originating in sending country		Problems originating in sending country	
Physical	Psychological	Formal	Informal
Injuries from war	A fear of those in authority given exposure to abuses of power	Restricted access to public services	Physical harassment of visible minorities
Injuries from beating and torture	Stress-related physical illness such as heart disease	Reproduction of homeland conditions in detention centres	Discrimination when trying to legitimately access public services
Rape and sexual assault	Separation from or disappearance of family/friends	Lack of awareness about opportunites to use services	Language problems prevent integration into opportunity structures
Malnutrition	Homesickness	Stress created from fear of deportation	Stress of adjusting to new cultural and social conditions
Injuries from persecution or imprisonment	Anxiety and stress from discrimination and persecution	Lack of language provision affects accessing services	
Exposure to communicable disease and poor sanitation in camps	Post traumatic stress disorder	Lack of specific and suitable services for certain cultural groups	
Poor primary health care and maintenance of medical records	Loss of human rights and life prospects		

Source: Adapted from BMA, *Asylum seekers: meeting their healthcare needs,* 2001, table 1

3. Trafficked and undocumented migrants

Migrants who enter the country through unofficial means, whether trafficked or otherwise, are exposed to a wide range of health risks. The very nature of the migration experience for these groups can result in specific psychological health problems; trafficked migrants are particularly vulnerable to health risks given their dependence on the trafficker.

The undocumented migrant workers are often exploited and work in unregulated or sub-standard conditions. This exposes these groups to health and safety hazards. The dependence of these migrants on their trafficker means that accommodation is often provided for them. These lodgings can be dirty and overcrowded exposing the migrant to the risk of communicable disease (Connelly and Schweiger 2000).

The experience of trafficked migrants is often gendered (Phizacklea 1994). Women trafficked to work in the sex industry face health risks while working – being exposed to STDs – but also when not working they face the risk of abuse by those who control them. The psychological health problems that are likely to arise as a result also have

to be taken into account – these women live in fear and have nowhere to turn because in giving themselves up to authorities they face the prospect of deportation.

These groups of migrants have no formal access to public service structures. In terms of health risks, this means that poor health may go untreated and be allowed to develop into a serious problem. Many undocumented migrants are reluctant to use NHS services because they fear that the health services may report them to immigration authorities that could act to remove them from the country. These factors can have grave effects on the health of undocumented migrants who, in forgoing medical treatment, allow their health problems to exacerbate and often end up in hospital Accident and Emergency departments with a problem that could have been prevented at an earlier stage.

Which migrants can access what health services?

Entitlement to access free NHS hospital treatment is based on 'ordinary residence' in the UK and *not* on British nationality or the payment of national insurance or income tax. Anyone deemed ordinarily resident in the UK is entitled to free NHS treatment; this is effective form the first day someone enters the country.

The criterion 'ordinarily resident' is a common law concept interpreted by the House of Lords in 1982 as 'someone who is lawfully in the United Kingdom voluntarily and for settled purposes as part of the regular order of their life for the time being, with an identifiable purpose for their residence here which has a sufficient degree of continuity to be properly described as settled'.[2]

This definition obviously has implications for the different types of migrant groups. The current entitlement to access of services is outlined below:

- *European Union citizens*: Nationals of member states of countries with bilateral healthcare agreements with the UK are entitled to free treatment by the NHS for any condition that arises during their time in the UK on the production of an E111 form. See Appendix B for a full list of bilateral agreements on health care.
- *Labour migrants*: People who have moved to lawful employment are automatically classified as 'ordinarily resident' and, therefore, are eligible for free NHS health care. This is contingent on the fact that their principal place of business is in the UK or registered as a UK branch.
- *Asylum seekers and refugees*: Asylum seekers are exempt from all charges for health care while their application is being processed, including during while waiting for any appeals they have lodged. Those granted refugee status or other forms of leave to remain continue to be entitled to free health care provided by the NHS during their stay in the UK. Those who have had their applications rejected and have exhausted all rights of appeal must pay for all medical care and treatment they receive. Applicants who have been in the UK for twelve months or more at the time their application was rejected can continue to receive any treatment they were receiving prior to the rejection. Any new course of treatment begun after that date will be chargeable. Unaccompanied children under 18, unsuccessful asylum applicants receiving 'hard case' grants and detainees all continue to be entitled to free NHS treatment.
- *Overseas students*: Students from a country with a reciprocal agreement are automatically exempt from healthcare charges. Students not from one of these countries must prove they are 'ordinarily resident' in the UK before they are exempt from charges. These rules apply to any long-term course for six months or more; those on short-term language courses are not included.
- *Former residents of the UK*: People who have lived lawfully in the UK for ten continuous years or more and have not been abroad for longer than five years

[2] See Home Office, http://www.ind.homeoffice.gov.uk/ind/en/home/laws___policy/policy_instructions/nis/l-p/ordinary_residence.html

are entitled to free health care provided by the NHS. British pensioners who spend no more than six months outside the country every year are also eligible for free treatment.

- *Spouses and dependants*: If the family member already in the UK is exempt from charges for health care, then their spouse or dependant is also entitled to free health care provided by the NHS, with the requirement that they live with the exempt person on a full-time basis. This excludes any family members visiting on holiday who would have the same rights as any other holiday maker.
- *Tourists*: Anyone in the UK on holiday or for a short-term visit will have to pay for any NHS treatment they might need while they are here unless they are visitors from a country with which the UK has a bilateral health care agreement.
- *Undocumented migrants*: Migrants living in the UK unlawfully, failed asylum seekers and people whose visa or entry clearance is not valid or has expired have no rights to free health care provided by the NHS, except for treatment in accident and emergency. Any treatment that directly follows this, however, must be paid for.

The above information is summarised below (table 9). The restricted access of some types of migrants to particular forms of health care represents a stratification of rights to health care in the UK. As the table below shows, undocumented migrants and failed asylum seekers have to pay for all health services apart from those needed in an emergency. These are already the most vulnerable groups of migrants and probably those with the least means to pay for health care. As a result it is likely that the psychological health problems endured by those whose application for asylum has failed or those who are controlled, manipulated and exploited by traffickers are exacerbated by their exclusion from formal structures of health care.

Table 9: Summary of entitlement to health services on the UK

NHS services free of charge to all	People entitled to free NHS treatment at any time		People entitled to treatment for condition arising in the UK	People who have to pay
	UK resident	Non-UK resident		
Treatment provided in accident and emergency, until patient is transferred as in-patient or to out-patient clinic	Those 'ordinarily resident' in the UK	Diplomats employed in UK embassies	Nationals of the EU and EEA, includng any legal residents, refugees or stateless persons	Unsuccessful asylum applicants who hve exhausted all rights of appeal
Primary care services which includes GPs, NHS walk in centres and NHS direct	Those who have come to the UK for employment with the UK being their principal place of business	UK pensioners living in another EEA member state for no more than six months	Nationals of countries with which the UK has bilateral agreements	Undocumented migrants
Diagnosis and treatment of certain communicable diseases and those to which specific public health enactments apply	Asylum seekers while the application is under consideration and refugees	Those employed on UK registered ships	Nationals of countries that are signatories to the European Social Charter but with whom the UK has no reciprocal agreement, limited to those genuinely without the resources to pay	Tourists who cannot prove they fall into one of the categories in the adjacent column
Treatment at clinic for STDs (HIV/AIDS treatment limited to diagnostic test and initial counselling)	Those who at time of treatment have been in the UK legally for twelve months	Members of HM armed forces	UK pensioners living abroad who have previously lived lawfully in the UK for ten continuous years	
	Unsuccessful asylum seekers receiving 'hard-case grants'		UK war disabled pensioners and war widows	
	Spouses or dependant children under 18 living with an ordinarily resident person on a permanent basis			
	Volunteers providing health or social services			

1. What is health tourism?

The phrase 'health tourism' is used to describe the phenomenon of foreign nationals visiting the UK with the primary intention of receiving free healthcare. Anecdotal evidence of pregnant women coming to the UK on tourist visas with the specific purpose of giving birth at an NHS hospital and business travellers bringing their family members over with them expressly to receive treatment (BBC News 2003*a*) has often been fuelled public fears that migrants who are not entitled to free treatment are abusing the healthcare system. There have also been suggestions that people with serious medical conditions deliberately seek asylum in Britain because they know they will receive free treatment while their claims are being assessed (BBC News 2003*c*).

However, little factual evidence exists about the true extent of 'health tourism'. The government suggests that it costs the NHS up to £200m a year (BBC News 2003*b*), although there is no clear evidence to support this. There are some indirect costs to the NHS in the long time taken to retrieve expenses from legitimate tourists who have insurance. Cornwall's health service is owed £2m for the care of visitors and it can take up to two years for the money to be paid by the Department of Health (BBC News 2003*a*).

In general though, many experts, including the BMA, question whether there is any evidence that health tourism was a significant problem (BBC News 2003*b*). Even if the extent of the problem was to cost the NHS the £200m a year, as suggested, this is a small proportion of the total NHS budget. If this problem were to be eradicated, then the NHS would still be left with more crippling difficulties such as waiting times or staff shortages; money spent on tackling health tourism could be better spent elsewhere (BBC News 2004*a*).

The scale of the problem is difficult to measure. Anyone who is ordinarily resident or exempt from charges (see table 8) is an NHS patient and, as such, separate records of those not ordinarily resident are not kept because, technically, they should not be treated. Figures also do not exist on the number of overseas visitors treated and charged under provision of the regulations.

Fears of sexual health tourism, especially of people with HIV and AIDS coming to the UK, are also unfounded because the evidence suggests that most people in this situation are not aware of their condition until they have fallen sick or because of antenatal screening (Boseley 2003).

Some anecdotal cost evidence was supplied by a leaked report from Newham General Hospital, an area of East London with a large number of asylum seekers and immigrant communities, suggesting that between September and November 2003 seventy-two people ineligible for treatment received services costing over £250,000 (BBC News 2004*a*). This led to the suspicion that health tourism may cost the hospital £1m a year. However, a further report by the same institution showed that in three months since the report, only seventeen patients were ineligible and received treatment worth only £32,000, a fraction of its £100m budget (BBC News 2004*a*).

2. Recent changes in the law

The Department of Health recently changed its regulations on the provision of healthcare to overseas visitors. From 1 April 2004 failed asylum seekers and others with no legal right to be in the country are no longer to be treated for conditions which start after their right has been denied; dependants of permanent residents in the UK are only to be entitled to free treatment if they are themselves permanently resident in this country; and business travellers and their dependants who fall ill while in the UK are also not be entitled to free treatment.

There is limited support from the medical profession for these changes. Some claim that health tourism is a significant enough a problem and that something should be done about those who abuse and exploit the NHS system (BBC News 2003*b*). Yet, there was also scepticism from the medical profession on two main counts. First, the there is the question of whether health tourism is actually on a large-enough scale to justify the attention by policy makers and health personnel. Secondly, there is concern over the role of doctors under the revised law. The BMA are adamant that it is not the role of the doctor to decide who is and who is not entitled to free treatment, but merely to treat those who need treatment. There is a concern that the new law put the onus onto the medical staff to act as 'state agents' of a discriminatory system, which goes against the central tenets of their professional ethics.

Health as a human right

In light of this recently proposed legislation, there has been discussion about how far any changes might impinge on a notion of a human right to healthcare. Whilst certain groups are ineligible for full NHS healthcare, some level of care is deemed necessary. Current UK regulations do not, however, allow treatment for HIV to illegal immigrants and failed asylum seekers on the NHS. There is some suggestion that this might result in 'unjustifiable harm' to infants of HIV positive mothers (Pollard and Savulescu 2004).

A current Department of Health consultation paper (Department of Health 2004) proposes further restrictions on the healthcare overseas visitors can receive. However, Pollard and Savulescu (2004) advocate an alternative position, that instead of restricting care we should allow access to free NHS care for overseas visitors and persons of uncertain residential status.

The article makes the argument on two levels: that healthcare professionals have a moral duty of care regardless of whether the harm occurs tomorrow or whether it occurs at any given point in the future and that any cost treatment incurred in the short-term will, in all likelihood, be a lot less than any incurred in the long-term. The paper argues that the 'NHS has a duty of rescue to treat such people, whenever a delay in treatment would have serious effects' (Pollard and Savulescu 2004). The authors argue that the cost incurred by the NHS of treating these individuals is actually fairly small in comparison to the considerable benefit to the individual. There is even a suggestion that by treating someone with HIV there is actually a saving to the NHS, because practitioners are taking preventative steps to diminish the need for emergency care later on which may prove long and costly. Perhaps the underlying principle is that whatever the legal status of a foreign visitor to the UK, they should not be in a position where they are allowed to die or suffer serious harm if, through treatment on the NHS, this could be prevented. While there may be a difference between an affluent foreigner who comes to the UK for treatment because it is cheaper than in their home country and a destitute failed asylum seeker (Sheather and Heath 2004), refusing to treat the latter would contradict a moral duty of care.

It is not just the human right of an individual's access to healthcare that is to be considered. When thinking about public health, the wider community has to be taken into consideration. Whilst testing for HIV is currently free for anyone, treatment depends on eligibility. There is an argument that as HIV is also a sexually transmitted disease and, therefore, as with other communicable diseases treatment should be provided on public health grounds. Likewise, under the proposed Department of Health legislation, children of failed asylum seekers will not have access to free immunisations and health surveillance. This has potentially serious implications for public health in terms of controlling the spread of childhood disease.

Medical practitioners and academics are generally in agreement that current levels of immigration do not suggest that there would be a considerable burden on the NHS if the current restrictions were relaxed. However they do recognise that this would only be possible if any care given on the grounds of health as a human right did not compromise the care of UK residents who pay into the NHS fund.

References

Aldous J, Bardsley M, Daniell R, Gair R, Jacobson B, Lowdell C, Morgan D, Storkey M, and Taylor G (1999), *Refugee health in London Key issues for public health* The Health of Londoners Project London: Directorate of Public Health http://www.lho.org.uk/Publications/Attachments/PDF_Files/refugees.pdf

All-Party Parliamentary Group on AIDS (2003) 'Migration and HIV: Improving Lives in Britain' London: *All-parliamentary Group on AIDS*, www.appg-aids.org.uk

BBC News (2003*a*) 'Treating tourists 'crippling' NHS' *BBC News Online*, 14 July, http://news.bbc.co.uk/1/hi/england/cornwall/3064099.stm

BBC news (2003*b*) ''Health tourism' rules unveiled' *BBC News Online*, 30 December, http://news.bbc.co.uk/1/hi/health/3355751.stm

BBC News (2003*c*) 'Tories Target Health Tourism' *BBC News Online*, 1 June, http://news.bbc.co.uk/2/hi/uk_news/politics/2954438.stm

BBC News (2004*a*) 'Are health tourists draining the NHS?' *BBC News Online*, 14 May, http://news.bbc.co.uk/1/hi/health/3356255.stm

BBC News (2004*b*) 'NHS dentists 'may get scarcer'', *BBC News Online*, 25 November, http://news.bbc.co.uk/1/hi/health/4038741.stm

Bach S, (2003), *International migration of health workers: Labour and social issues* Geneva: International Labour Office

Barratt A, Trevena L, Davey H, and McCaffery K, (2004), 'Education and Debate: use of decision aids to support informed choices about screening', *British Medical Journal*; 329:507-509

Boseley S (2003) 'Sexual healing' *Guardian*, 19 June

British Medical Journal Editorial, (2004), 'Ethnic profile of the doctors in the United Kingdom', *British Medical Journal*, 329: 583-584

British Medical Association (2002) *Asylum seekers: meeting their healthcare needs* London: BMA

British Medical Association (2004) 'Refugee doctors: a BMA briefing paper' London: BMA, http://www.bma.org.uk/ap.nsf/Content/5E48AB1C26...

British Medical Association (2004) 'Asylum seekers and their health' London: BMA http://www.bma.org.uk/ap/nsf/Content/1BA8F7936FC904

British Medical Association and Refugee Council (2004), *Refugee Doctors Database*, http://www.bma.org.uk/ap.nsf/Content/Refugeedoctorstats

Burnett A and Peel M (2001) 'Asylum seekers and refugees in Britain what brings asylum seekers to the United Kingdom?' *British Medical Journal*, 322:485-488

Carvel J (2003) 'Claim on cost derived from debt agency' *The Guardian*, 31 December

Centre for the Advancement of Health (2000) *Refugee Health Compromised by Stress*, http://www.hbns.org/newsrelease/refugee10-31-00.cfm

Chanda R (2002) 'Trade in health services', *World Health Organisation Bulletin*, 80 (2)

Clinton-Davis L and Fassil Y (1992) 'Health and social problems of refugees' *Social Science and Medicine*, 35(4):507-513.

Coker R (2004) *Migration, public health and compulsory screening for TB and HIV*, ippr Working Paper, London: ippr

Connelly J and Schweiger M (2001) 'The health risks of the UK's new asylum act', *British Medical Journal*, 321:5-6 (1 July) http://bmj.bmjjournals.com/cgi/content/full/321/7252/5?ijkey=ed35f2ef73d6ed03f9670c4a5cf55cc58d896d47&keytype2=tf_ipsecsha

Department of Health (2004) *Proposals to Exclude Overseas Visitors from Eligibility to Free NHS Primary Medical Services, a Consultation* http://www.dh.gov.uk/assetRoot/04/08/22/67/04082267.pdf

Dobson R (2004) 'Poor countries need to tackle the health brain drain', *British Medical Journal*, 329: 419

General Dental Council (2001) *Annual Review 2001*, London: GDC, http://www.gdc-uk.org/pdfs/GDC_Annual_Review.pdf

General Dental Council (2002) *Annual Report 2002-2003*, London: GDC, http://www.gdc-uk.org/GDC_Annual_Report.pdf

General Dental Council (2003) *Annual Report 2003*, London: GDC, http://www.gdc-uk.org/pdfs/annual%20report%202003.pdf

General Medical Council (2002) *Annual Reports and Accounts*, London: GMC, http://www.gmc-uk.org/download/report2003.pdf

General Medical Council (1998) *Medical Registration Statistics*, London: GMC, http://www.gmc-uk.org/register/stats/MedRegStats1998.pdf

Gilmore N (1998) *Human Right Issues and Migration*, presentation at the 12th World AIDS Conference, Geneva, July

Goldacre M and Davidson J (2004) 'Country of training and ethnic origin of UK doctors: database and survey studies' *British Medical Journal*, 329: 597

Hinsliff G (2003) 'Failed asylum seekers lose free NHS care', *Observer*, 21 December

Carey-wood J, Duke K, Kam V and Marshall T (1995) *Research Findings No. 16: The settlement of Refugees in Britain*, London: Home Office

International Organisation for Migration (2004) 'Trafficking in human beings and health implications' Seminar on Health and Migration, 9-11 June http://www.iom.int/DOCUMENTS/OFFICIALTXT/EN/IOMtrafficking9_11June.PDF

Jones D and Gill P (1998) 'Refugees and primary care: tackling the inequalities', *British Medical Journal*, 317:1444-1446 http://bmj.bmjjournals.com/cgi/content/full/317/7170/1444?ijkey=052c664bfba8234589ce409e25fb95d0a6b64df8&keytype2=tf_ipsecsha

Medical Foundation for the Care of Victims of Torture (2004) *Asylum: Myths and Facts*, http://www.torturecare.org.uk/about/aboutMyths.html

National Asylum Support Service (2004), *Dispelling the Myths, Telling the Facts*, London: NASS

Organisation for Economic Cooperation and Development (OECD) (2003) *Trends in International Migration 2003*, Paris: OECD http://www1.oecd.org/publications/e-book/8103061E.PDF

Phizacklea A (1998) 'Migration and Globalisation: A Feminist Perspective', in Koser K and Lutz H (eds.), *The New Migration In Europe*, Basingstoke: Macmillan

Pollard A and Savulescu J (2004) 'Eligibility of overseas visitors and people of uncertain residential status for NHS treatment', *British Medical Journal*, 329: 324-329

Sheather J and Heath I (2004) 'Policing access to primary care with identity cards', *British Medical Journal*, 329:303-304

Sinnerbrink I, Silove D, Field A, Steel Z, and Manicavasagar V (1997) 'Compounding of premigration trauma and postmigration stress in asylum seekers', *Journal of Psychology*, 131 (5): 463-70, http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=retrieve&db=pubmed&list_uids=9284551&dopt=Abstract

Socialist Worker (2004) 'Facts go walkabout on 'health tourism'', 10 January, Issue 1883, http://www.socialistworker.co.uk/article.php4?article_id=120

Sundquist J, Bayard-Burfield L, Johansson LM, Johansson SE (2000) 'Impact of ethnicity, violence and acculturation on displaced migrants: psychological distress and psychosomatic complaints among refugees in Sweden' *Journal of Nervous and Mental Disease*, June, 188 (6): 357-65. http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=retrieve&db=pubmed&list_uids=10890344&dopt=Abstract

United Nations Economic and Social Council (2002) 'Substantive Issues Arising In The Implementation Of The International Covenant On Economic, Social And Cultural Rights', *General Comment No. 14: The right to the highest attainable standard of health*, http://www.unhchr.ch/tbs/doc.nsf/(symbol)/E.C.12.2000.4.En?OpenDocument

Williams R (1993) 'Health and length of residence among south Asians in Glasgow: a study controlling for age', *Journal of Public Health Medicine*, Vol. 15(1): 52-60

Woodhead D (2000) *The Health and Well-Being of Asylum Seekers and Refugees*, London: The King's Fund, http://www.kingsfund.org.uk/pdf/ASAR.PDF

Wyss B (2004) 'Global Poaching: Jamaica's Brain Drain', *Econ-Atrocity Bulletin*, 30 January

Appendices

Appendix A: Diseases for which treatment is exempt from charges

Acute encephalitis	Meningitis	Scarlet fever
Acute poliomyelitis	Meningococcal septicaemia	Smallpox
Amoebic dysentery	Mumps	Staphylococcal infections
Anthrax	Ophthalmia neonatorum	Tetanus
Bacillary dysentery	Paratyphoid fever	Tuberculosis
Cholera	Plague	Typhoid fever
Diphtheria	Rabies	Typhus
Food poisoning	Relapsing fever	Viral haemorrhagic fevers
Leprosy	Rubella	Viral hepatitis
Leptospirosis	Salmonella infection	Whooping cough
Malaria	Severe Acute Respiratory Syndrome (SARS)	Yellow fever
Measles		

Source: Department of Health, http://www.dh.gov.uk/assetRoot/04/08/22/67/04082267.pdf

Appendix B: UK's bilateral healthcare agreements

European Economic Area countries (EEA)	*Nationals of the following countries*	*Residents of the following countries (irrespective of nationality)*
Austria	Armenia	Anguilla
Belgium	Azerbaijan	Australia
Cyprus	Belarus	Barbados
Czech Republic	Bosnia	British Virgin Islands
Denmark	Bulgaria	Channel Islands
Estonia	Croatia	Falkland Islands
Finland	Georgia	Iceland
France	Gibraltar	Isle of Man
Germany	Kazakhstan	Montserrat
Greece	Kirgizstan	St. Helena
Hungary	Macedonia	Turks and Caicos Islands
Iceland	Moldova	
Italy	New Zealand	
Latvia	Romania	
Liechtenstein	Russia	
Lithuania	Tajikistan	
Luxembourg	Turkmenistan	
Malta	Ukraine	
Netherlands	Uzbekistan	
Norway	Yugoslavia (Serbia & Montenegro)	
Poland		
Portugal		
Republic of Ireland		
Slovakia		
Slovenia		
Spain		
Sweden		
Switzerland		