



Health status, health behaviour and healthcare use among migrants in the UK: Evidence from mothers in the Millennium Cohort Study

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ABSTRACT

The health of migrants in the UK and their access to healthcare is of considerable policy interest. There is evidence of ethnic inequalities in health and access to and use of healthcare but insufficient consideration of the importance of birth abroad and length of residence in the UK. This study examines indicators of health status, behaviour and healthcare use among mothers of infants in the Millennium Cohort Study, according to whether born in the UK or abroad, individual ethnic grouping, and length of residence. Our findings show there are both positive and negative health indicators associated with ethnicity, birth abroad, and length of residence and presenting results on a single factor in isolation could lead to a misinterpretation of associations. For mothers ethnicity has an important relationship with most health indicators independent of country of birth, length of residence and socio-demographic circumstances. Once adjusted for ethnicity and socio-demographic variables, association with birth abroad disappears for most health outcomes suggesting that there may not be an independent migrant penalty in health. There is a linear trend in decreasing health status with increasing length of residence but no independent association between length of residence and healthcare use. This suggests that while there are continuing barriers to good health for migrants in the receiving society as shown in other studies, factors important for one health outcome may not apply to another. Our findings challenge linear acculturation models for migrants' health in showing that a linear trend in improving socio-economic circumstances for mothers in some ethnic groups is not always associated with better health outcomes or changes in health behaviour. Our results point to a need for a comprehensive collection of information and analysis for all categories of migrants for understanding patterns of and factors underlying health and use of healthcare.

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Introduction

The health of migrants in the UK and their access to healthcare is of academic, policy and practitioner interest. There has been a rise in net immigration over the last few decades that has resulted in a greater share of non-UK born people in the total population. Non-UK born people made up about 11% of the total UK population in 2008 (Office for National Statistics, 2009). The diversity of migrants in the UK today in terms of countries of origin, ethnicity, socio-economic circumstances, religion, legal status and length of residence, has significant implications for their health status and needs, and entitlement and access to healthcare.

This paper examines the relationship of some of these factors with the health of mothers of infants, through analysis of data from

a national population-based study. It adds to previous research on such mothers by throwing light on the association between being a migrant (birth abroad), ethnicity, length of residence in the UK and socio-demographic circumstances, and their health status, health behaviour and healthcare use.

Background

The health of migrants is a key indicator of 'integration' within receiving societies, alongside employment, education and housing (Spencer & Cooper, 2006). UK research evidence on the health of migrants, particularly recent migrants, is patchy, with greater focus on minority ethnic groups some of whom are UK born (Piachaud, Bennett, Nazroo, & Popay, 2009; Fitzpatrick, Jacobson, & Aspinal, 2005). Ironically, since the early 1990s when ethnic group information collection in the Census began, there has been a reversal of the situation in the 1970s and 1980s when mainly only country of

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birth was recorded, such that the emphasis recently has been on providing a complete account of ethnic variations in health data, for example in hospital and primary care data (Richardson & Mmata, 2007; Warburton, 2008). However, existing evidence does not always include country of birth and date of arrival in the UK.

Not surprisingly, current health policy, which relies on routine and population survey data, primarily focuses on ethnic inequalities. The government's Public Service Agreement (PSA) target to reduce health inequalities focuses on achieving improvements in cross-cutting social determinants of health. The evidence is mainly given by ethnicity, rather than including country of birth and date of arrival for migrants, apart from mortality statistics where only country of birth is recorded (Acheson, 1998; Health Inequalities Unit, 2008). The evidence for ethnic inequalities in health is well documented (Commission for Healthcare Audit and Inspection, 2008; Marmot et al., 2010; Sproston & Mindell, 2006). However, the literature on ethnic inequalities in health is often separate from evidence and policy concerns about the health of migrants; the latter being focused more specifically upon the association between source country conditions, the trauma of the migration process and issues around entitlement to care and the health of asylum seekers and refugees, or on the prevalence of particular diseases such as Tuberculosis or HIV (Health Protection Agency, 2006; Piachaud et al., 2009).

Our focus in this paper is on mothers of infants (under one year), for whom there is evidence of ethnic inequalities in health. A study in England found that Black and Minority Ethnic (BME) women accessed antenatal care later than White women, and were less likely to report offer and uptake of screening for Down's Syndrome and to feel they were treated with respect by health professionals. Non-UK born BME women compared to UK-born White women were less likely to be offered antenatal classes and reported less access to care options. All and specifically non-UK born, BME women were significantly more likely than White women to report poor health postnatally (Redshaw, Rowe, Hockley, & Brocklehurst, 2007).

The most recent Confidential Enquiry into Maternal Deaths (CEMD) in the UK shows that in 2003–2005 Black African mothers, followed by Black Caribbean and Middle Eastern mothers, had significantly higher death rates than White mothers. Higher percentages among minority ethnic mothers who died than among White mothers, reported late booking (>22 weeks) or no antenatal care, and in the total number of maternal mortalities, the percentage of mothers who spoke no English was relatively high. Of the 35 Black African mothers who died, 4 were UK citizens, the rest mainly being recent migrants including asylum seekers and refugees. The report notes the rise in numbers of recent migrants among mothers who died since the last confidential enquiry, including for the first time, mothers from EU Accession countries (Lewis, 2007).

A national population study revealed that Black African and Black Caribbean women in the UK had more than double the risk of severe maternal morbidity than White women, a pattern that is similar to ethnic differences in maternal death rates. Non-White women had a significant increased risk of severe morbidity than White women even after adjustment for other factors (Knight, Kurinczuk, Spark, & Brocklehurst, 2009). This study raised questions about factors associated with ethnic differences in severe maternal morbidities such as differences in access to care. Local and qualitative studies of minority ethnic women in the UK have also highlighted poorer health outcomes and inequalities in access to information and maternity care linked with factors such as lack of English fluency and constrained material circumstances (Jayaweera, D'Souza, & Garcia, 2005; Katbamna, 2000). There is recognition of gaps in data collection and analysis restricting interpretation of results and a call for more information on mothers' countries of birth, languages spoken, and length of residence for migrants in receiving societies,

to gain a fuller understanding of maternal health inequalities (Pollock & King, 2009).

In the wider UK population, the limited evidence suggests that most migrants have relatively good health but that the health status of some migrants deteriorates after arrival (Johnson, 2006). In some accounts the concept of 'acculturation' – the adoption of norms, values and behaviour in the receiving society – is used to explain changes in migrants' health – for instance, the impact of increased levels of smoking and processed diets on cardio-vascular disease and cancer (Zaman & Mangtani, 2007). But there is also recognition of theoretical and empirical limitations of using models of acculturation to understand migrants' health (Abraldo-Lanza, Armbrister, Florez, & Aguirre, 2006; Hunt, Schneider, & Comer, 2004). Other accounts place greater emphasis on structural barriers to good health and care such as socio-economic deprivation including sub-standard housing and poor quality food, migrants' lack of knowledge of, access to and uptake of screening and immunisation, and inadequacy and insensitivity in support – including language support – given by healthcare providers (Johnson, 2006).

Thus, while there is growing concern about the health of migrants and barriers they face in accessing healthcare, much evidence in national data sets has not yet been extracted for migrants given primary focus on ethnic inequalities in health. The aim of this paper is to examine the relationship between country of birth (born in the UK/born abroad), length of residence in the UK, and ethnicity, and health status, health behaviour and healthcare use, through secondary analysis of a population-based study of mothers of infants. The term 'migrant' is used in this paper in the broadest sense to refer to mothers born outside the UK. The research question addressed is whether there is specifically a migrant penalty or benefit in health for such mothers, taking into account length of residence, ethnic, demographic and socio-economic differences. The results reported in this paper strengthen the evidence base on the health of migrants and their healthcare use in the UK over time, and provide new insights for policy making and service delivery as well as identifying gaps in the evidence base for future research.

Methods

The Millennium Cohort Study (MCS) is a national longitudinal birth cohort study which follows a sample of children born in the United Kingdom at the beginning of the new millennium (Dex & Joshi, 2005; Plewis, 2007). Sweep 1 of the study was carried out in 2001–2002 when infants were about 9 months old. The sample included 18,818 infants selected from child benefit records. Families not eligible for universal benefits, such as those with legal statuses that preclude them from access to public funds and services were not eligible for the MCS. Among the excluded are those most likely to face barriers in accessing free healthcare, such as undocumented migrants and failed asylum seekers (Medact, 2007). The sample design was a random two-stage sample by electoral ward with oversampling of families living in the smaller UK countries, in high ethnic minority density wards (electoral wards in England where at least 30% of residents were from a (Black or Asian) minority ethnic group in the 1991 Census), and in wards in all four UK countries which were in the poorest quarter of the Child Poverty Index. The interview response rate was 85% for the UK sample (Plewis, 2007). In Sweep 1, 1% of main interviews were done in a language other than English and 3% in English and another language (Hansen, 2008).

Participants

The analyses reported in this paper are based on data collected in Sweep 1 on health and socio-economic circumstances of families.

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