Challenges in improving the health of migrants: a qualitative study with public health professionals

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“…when you unpeel an onion, the onion gets smaller. When I unpeeled this onion, the onion got bigger...”

Background

Foreign-born residents of England have worse health outcomes than natives and reasons for this are complex and varied, including:

- lack of familiarity with systems;
- confusion around entitlement to care;
- inadequate information;
- insensitivity to cultural requirements;
- different cultural understandings of illness and treatment;
- insufficient support for non-native speakers;
- and social deprivation and traumatic experiences

(Priebe et al. 2011; Akhavan & Karlsen 2013).

Background

- The re-organisation of health services in April 2013 created new challenges for public health professionals (PHPs) who now work in a democratic environment and must work across organisations to achieve objectives.
- Since these changes, there has been no research exploring challenges faced by PHPs in the UK who are aiming to improving migrant health.

This research

- My research aimed to understand these challenges; to explore how cultural differences and concerns over cultural insensitivity impact the work of PHPs; and make recommendations if appropriate.
- A pragmatic approach was taken and 11 semi-structured interviews and 2 focus groups were conducted with PHPs working at Public Health England (PHE) or local authorities across Yorkshire and Humber (YH).

Findings

Five complex and inter-related themes, with sub-themes were identified

Theme 1. ‘Politics’

The negative impact of political influences on PHP ability to improve the health of migrants came up in every interview & focus group.

- A negative political narrative was described (linked to the Brexit vote by participants) and it was suggested that this had legitimized derogatory, discriminative and unacceptable perceptions, including the perception that migrants shouldn’t be entitled to services that are tailored to meet their specific health needs.

Example quote:

"…when the Hepatitis B programme was introduced where some practices would test and provide vaccination for Hepatitis B for some new migrants, UKIP issued a statement to the press saying that they objected to this money being spent on migrants, to which the response from the LA was extremely vigorous, and the response from the Director of Public Health was that we provide healthcare to those at need, free at the point of delivery, and that's what we do that's fundamental to the constitution of the NHS, now obviously it was the CCG that had made the decision to fund that with public health advice but the DPH, Director of Public Health at the time felt that that was important and we agreed to make the point that we are not about rationing services that people need because they are migrants"

Theme 1. ‘Politics’

- Participants said that public health staff with an ethnic minority background were often perceived as biased, ‘favouring’ those of a similar ethnicity, resulting in them asking their white colleagues to present their work about migrant health.

Example quotes:

"…*it counts against you if you are from a minority, 'well you would say that', yeah… People feel individually at risk and that there is almost an acceptance that it is ok to attack, that wasn't there before."*

"…He will say to me, 'but if you present the findings of this, people will listen in a different way to if it was my face presenting this.' We didn't used to talk that way."

Theme 1. ‘Politics’

- Participants described how the current government places no importance on migrant health and how migrant health needs are primed as problems of another society that has come to England.

Example quotes:

“*I don't hear much from Department of Health, I don't hear a public health minister talk about this agenda”*

“I think it's perpetuated in the system that it's an additional need, it's not a need within our society, it's another societies' need that's come to us.”

“I just think those interactions with professionals are preloaded by a- it's a problem, it's a problem in its own right and it's going to create other societal problems, be that school places, not enough nurses, you name it”

Theme 2. Impact of negative narrative

The negative political narrative has been widely broadcast in the media and has influenced the negative narrative in society. Participants reported a huge impact on the lives of migrants.

- They felt that the consistent negative narrative is often accepted by the public without question.

Example quotes:

“I think that there are also things that are convenient for some people to say which aren’t true. So the: ‘they are taking our jobs’, no they’re not, nobody else wants those jobs”

Established communities that have been in the UK for over a hundred years *“…feel like they are being told that was a mistake we shouldn’t have been let you in.”*

Theme 2. Impact of negative narrative

- They described a change in cultural acceptance where migrants are no longer wanted. This change is said to have led to intolerance becoming acceptable and bias and discrimination becoming commonplace.

Example quotes:

"…micro populations have not got the priority that they had before, and it's almost- there is a sense of an acceptance to that which is surprising …it feels as though there is now a majority in the country who don't support diversity. Now, I'm not sure that that was what the Brexit vote was about at all, but that's the feeling that I think it has caused for some policymakers."

"I think that immediately after the Brexit vote it gave- the outcome of the result gave some groups in society the feeling of legitimacy that they were able to express views that were previously unacceptable like go home now, people had on their tee shirts, which was given more legitimacy by the Brexit vote"

Theme 2. Impact of negative narrative

- They acknowledge that hearing something enough can have an impact on a person's perception, even extending to PHPs who might hold unconscious biases.

Example quote:

"…i*t's got to be in some people's delivery of service of how they consider different things they do and how they treat people. And I'm not saying we can solve that."*

"I'd like to say they're impartial, which is how I am I think…I try not to be biased…I don't think I do enough and I feel a bit critical about my role sometimes, that we do white British most of the time you know, whenever we do a consultation you can guarantee that most of the responses that come back are white British. Health promotion stuff we do, you know, we still tend to get more white British people, but that's just the nature of the beast isn't it."

Theme 2. Impact of negative narrative

- They described how migrants have lost trust in authorities, including those trying to help them, and directly attribute this to the campaigning around the Brexit vote. This has created a feeling of loss, sadness and frustration amongst PHPs.

Theme 3. Lack of knowledge

- PHPs were very honest throughout data collection and admitted not knowing much about migrant health. They feel they have a lack of data, a lack of knowledge about migrant cultures and beliefs or they just don't know where to start. Differences in health belief systems is said to be a challenge.

Example quotes:

“As far as I am aware, I’m not, to be honest, I don’t know. That is an issue really, that we don’t really know what we’ve got really to be honest. It’s not something we focus on or…we see ourselves as not having many [migrants] *we don’t really focus on it, but we do know that the- like the Polish population is increasing but as to what rate and where they actually are, I don’t know to be honest. @”*

“I don't think we know [what the problems are]*, if I'm brutally honest, I don't think hand on heart at local level we know or understand that. I've yet to see something that tells me what those issues are.”*

Theme 3. Lack of knowledge

- Participants described migrant health as too difficult and because of this; most of the work they carry out is tokenistic and doesn’t make real change.

Example quotes:

“I’ve used the analogy several times before with this piece of work, when you unpeel an onion, the onion gets smaller. When I unpeeled this onion, the onion got bigger, do you know, and more complex.”

“I suppose the danger is you always go for the automatic quick wins that can be measured.”

“Part of those discussions during that period was like, this is just incredibly, unbelievably hard and complex and as an indicator of how complex it is and how many people you need sat around the table and really with the end result of actually- not having to start again in the development of services, but not far off- is that it has never been done. Why hasn’t it been done? Because it is definitely, I think, this is my own personal opinion, it’s in the really hard to do box, that is locked inside the hard to do box, that no one knows where the key is.”

“In a systematic way if you think the standard way of doing equality and impact assessments on a big programme, people are willing to say ‘oh yes, we’ve taken it into account’, but it’s not real.”

Theme 3. Lack of knowledge

- Lack of cultural awareness is also a barrier. Participants describe occasions when they have tried to improve migrant health but have made errors that were culturally insensitive.

Example quotes:

“We were completely tone deaf to that conversation because there were people at national level who said ‘but we asked the Imam and its fine’. It’s like no there isn’t an Imam, there are Imams and that’s not how the system works. You obviously don’t understand this culture.”

“…so they went, ‘see your poster? Where the top of it says ‘Are you pregnant?” they said that you might as well be saying and excuse my French, ‘have you been shagging then come here next Tuesday for the next six weeks.’ And I just put my heads in my hands and went, oh god, another lesson in life.”

Theme 3. Lack of knowledge

- Some of these errors can be attributed to making assumptions or stereotyping groups as homogenous, which participants describe as necessary to undertaking their work but dangerous in this context as you lose some of the complexity, for example:
  - incorrectly attributing A&E presentation for non-urgent illness to a specific group like the Roma population, instead of understanding that this is a behaviour of all new migrant groups due to a lack of understanding of the healthcare system in England.

Example quote:

“People have a very- view of migrants as homogenous groups, you say the Somali community and make them a homogenous group when actually in Somalia they are all at war, that’s why they came over here, so they’re not, they’re not from the same group at all, in fact, it’s even worse than being neutral because they were actually fighting against each other.”

Theme 3. Lack of knowledge

- GP registration is important in the UK as it is the gateway in to healthcare. We know from the background literature that very few migrants register with a GP.
- Throughout the data there is a consensus that some GP practices do not want to register migrants. This is strongly linked to the negative narrative in society and can be detrimental. It is suggested that sometimes this stems from confusion around the legality of registration and has been complicated by the immigration act which states that some services are now chargeable.

Theme 3. Lack of knowledge

- There was a lack of understanding by some participants of the public health objective to reduce differences between groups.
- Some did not understand that this requires inequality in resource distribution in order to generate equality in health, and felt that we should do the same for all groups. This is a key concern for public health organisations and should be addressed immediately.

Example quote:

“I mean health inequalities is a nightmare really because we should be reaching out to all the population regardless of whatever protected characteristics. So for me you could argue we should be doing it for everybody.”

Theme 4. Resources

- Participants describe fragmentation that is underpinned by the current political will and the changes brought about by the Health and Social Care Act (2012).
- It's described as professionals operating in different organisations, with different priorities, in the context of a changing PH world, with changes to programmes, restructures and reorganisations common.
- Communication between organisations is described as an issue sometimes resulting in duplication, but most participants report excellent working relationships.

Theme 4. Resources

- Financial constraints are discussed and have resulted in both a reduction of public health staff and third sector groups that are commissioned to do targeted work with marginalised and vulnerable groups like migrants.
- There are even disincentives within the system that further prevent action being taken, with incentives only to do more of what is being done well.

Theme 4. Resources

- Commissioning of services is also a challenge in such a fragmented system because spending money in one organisation (like LA), saves money for another (like NHS providers) and there is a reluctance to spend limited budgets on initiatives that have no savings for the individual organisation, even if it is the right thing to do for health.

Example quotes:

“So often spending in the LA saves money in the NHS and that is a thing where if we could have a system wide of how it is organised it would be easier for the system to spend money on one place and save money in another, without it being, well, we can’t spend money here, to save you money because we are not in that position of having lots of cash.”

“It is like Pandora’s Box, because then you have the other issues of there is reduced services and then those questions for commissioners and people that are in charge of budgets. Do you put your funding in very pin point areas of need or do you spread that jam over a wider population base?”

Theme 5. Future support needed

Participants suggest that the following support would help them improve the health of migrants:

- Receiving formal training about their population and embedding regular professional development that includes knowledge of the local population, health inequalities, different cultures, ethnicities and health needs.
- Centralised training or support for the production of data would be helpful in allowing PHPs to use their time more efficiently.
- National PHE should support LA's by providing collated literature for targeted work with vulnerable groups, saving time and duplication across the country.
- Using tools for assessing health inequalities in a more systematic way might provide practitioners with support to instigate change for disadvantaged communities.
- Key Performance Indicators (KPIs) to monitor the progress of organisations tasked with reducing health inequalities.

So what does this mean?

Equity and inequality interplay

- Existing migrant health initiatives can be tokenistic
- Some participants felt that everyone should be treated equally and have the same access to care, raising questions about PH objectives

Politics theme: adding to existing literature

- All themes and subthemes are connected to the ‘politics’ theme in some way
  - The ‘negative narrative’ theme is strongly related to political direction and priority of local and national government
  - The lack of importance placed on migrant health politically influences the lack of knowledge PHPs have about migrant groups
  - Attempts to address some of the issues (like access to healthcare) at an operational level will be consistently undermined by the political negative narrative.
  - Health systems budgets set by national government are repeatedly reduced
- Did not emerge as a theme in any research with UK health professionals

Adding to existing literature

Further new concepts include:

- increased intolerance in society;
- migrant health primed as a problem, increasing division;
- migrant health avoided by PHPs as it is difficult to change.

Recommendations

1. National government should utilise every opportunity to support the reduction of inequalities in all aspects of society. For migrant health, this would involve making use of the PHE remit letter issued yearly by the Department of Health. Reports like ‘Fair Society, Healthy Lives’ (Marmot, 2010) should be supported wholeheartedly with corresponding funding and national strategy that can then be adopted locally.
2. National and local government should work towards integration of all UK residents into an inclusive and equitable society, whether they are foreign or native born.
3. Greater financial investment into public health should be made by national government.
4. The Association of Directors of Public Health should work with Public Health England to agree which tools for assessing and reducing inequalities will be routinely used by public health staff across the UK. Training should then be provided to staff on how to use these tools and share learning.
5. A forum for public health professionals in the UK to share learning should be provided on an electronic platform, ensuring that reduced budgets don’t mean reduced opportunities for growth, development and sharing successes.

Recommendations

6. Training should be provided for all local authority, Public Health England and health and social care staff, to help them to understand the impacts of inequality on the lives of the people that they work with; the difference between equity of access and equity of health; and information about the different communities and vulnerable groups within the population that they serve.
7. Training should be provided to support PHPs with data analysis and presentation.
8. Key Performance Indicators (KPIs) should be introduced at all levels of commissioning to hold organisations to account for reducing inequalities.
9. PHE should conduct centralised literature reviews to save time and duplication for PHPs and increase capacity.
10. Where staff are employed by one organisation (e.g. PHE or local authority) and embedded in another (e.g. NHSE or CCG), support should be provided to these staff to empower them to uphold the values and priorities of public health and prevention within an environment that favours the medical model.

Recommendations

11. Managers of public health staff should legitimise time for their staff to understand the communities they work with, share learning with other professionals and talk about the challenges that they face with others.
12. Information should be produced for visitors to England about the structure of the NHS in easy-read format, so that it can be understood by all languages. Requests should be made for airports to display this information and make leaflets available.

Thank you for listening

For a copy of full report, exec summary or further information, please email:

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Questions?