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Title

Public health practitioners' perspectives of migrant health in an English region

Abstract

Objectives: Migration is a complex and contested topic of public debate. Professionals working in public health must negotiate this politicised complexity, yet few studies examine the perspectives and practices of public health professionals in relation to migrant health. This study seeks to redress this by exploring how migrant health is conceptualised and addressed by public health professionals after a key transitional point in the reorganisation of public health in England and the public vote for the UK to leave the EU.

Study design: Qualitative in-depth exploratory study

Methods: Ten interviews and one focus group were conducted with 14 public health professionals' working at Public Health England (PHE) or local authorities in an English region. Recordings were transcribed and thematic analysis was conducted.

Results: Professionals viewed migrant health mainly through a health inequalities lens; migrants were considered vulnerable and their health often determined by wider social issues. This influenced public health professionals' perceived ability to affect change. Public health professionals were greatly influenced by the societal, policy and institutional, post-Brexit vote context in England, describing a nervousness around addressing migrant health. At an institutional level, public health professionals described a sense that migrant health was not prioritised. It was considered 'too hard' and complex, especially with shrinking resources and highly politicised social narratives. Consequently, migrant health was often not directly addressed in current practice. The gaps identified by public health professionals were: lack of knowledge of health needs and cultural difference; lack of access to appropriate training;

lack of cultural diversity within the public health workforce; and concerns about meaningful community engagement.

Conclusions: These findings raise concerns about public health professionals' ability to address the health needs of migrants living in England. The gaps highlighted require further and deeper examination across relevant organisations including the broader public health infrastructure in the UK.

Keywords

Migrant health; Public health professionals; Brexit; Public health reorganisation

Introduction

The health of migrant groups[1] is increasingly important as flows of people across the world grow and show little sign of abating. Social instability, economic inequality and globalized economies are driving mass movement both within and between global regions (1). Migrants generally arrive healthy, bringing social and economic advantages to the host country (for example, paying additional tax and, providing labour supply)(2–5). Despite an overall and initial 'healthy migrant effect' on host countries, some new arrivals are exposed to circumstances that impact negatively on both physical and mental health, either during their journey, or following arrival (6–8). In addition, the health of migrants often deteriorates over time and converges to host society levels within 10-20 years after arrival. Migrant populations in the US, Canada, Australia and Europe have been shown to develop high

[1] There are many terms used to classify migration status, often used interchangeably (Anderson & Blinder 2015). For the purposes of this paper, 'migrant' is an umbrella term encompassing people who are moving or have moved across an international border or within a State away from their habitual place of residence, regardless of (1) the person's legal status; (2) whether the movement is voluntary or involuntary; (3) what the causes for the movement are; or (4) what the length of the stay is (39).

comorbidity and disability rates in old age (9). This decline could be attributed to cumulative stressors, including the migration journey, adaptive stress, experiences of discrimination, poor access to healthcare, economic stressors and convergence with the health behaviours of the host society (9). Refugees, asylum seekers and migrants without documentation are in particularly vulnerable circumstances and may experience particular health risks such as exposure to communicable diseases (10,11).

Migration is highly politicized in Europe and is a topic of social contestation and controversy. It is unsurprising that migrant health occupies an ambiguous position in the English public health system. National public health guidance indicates that migrants are viewed mostly through the lens of communicable disease and managing potential population health risks. Public Health England's (PHE) migrant health guide, for example, primarily focuses on health protection and controlling infectious disease., (12). Health Matters (13), a government resource which contains 'facts, resources and information on major public health issues for public health professionals, local authorities and CCG commissioners' acknowledges migrants as an 'underserved group' in the only communicable disease chapter (12). There is indicative signs that other conceptualizations exist; in the health equity collection of the government website, migrants are referred to under 'inclusion health', implying an awareness that migrants are often excluded from health systems and services and may have specific health needs (14).

Previous research with Health Care Professionals (HCPs) has identified barriers to accessing healthcare for migrants across Europe, including: lack of familiarity with health systems; confusion around entitlement to care; inadequate information; insensitivity to cultural requirements; different cultural understandings of illness and treatment; insufficient support for speakers of other languages; social deprivation and traumatic experiences (15–17). A UK study with HCPs concluded that creating a 'fit' between patients and practice is complex and

problematic (17). Despite some HCPs acknowledging the role of the organisation in creating a better fit for patients, these studies match the prevailing medical model and place responsibility on individuals, rather than taking a population-level health approach (18,19).

Previous research has not explored the perspective of Public Health Professionals (PHPs), who are now essential to the commissioning of health services following substantial changes introduced to the English health system in the form of the Health and Social Care Act (2012) which came into force in April 2013 (20). These changes meant the creation of new organisations like NHS England and Clinical Commissioning Groups (CCGs) and the movement of public health from the NHS to local authorities. Public Health England was created to bring together public health specialists from over 70 organisations into a single public health service (21).

Professional perspectives of migrant health are, therefore, important and are currently operating in a transitional and fluid context. Layered on top of this institutional change are continuing cuts to local authority budgets, austerity in England and social unease and political posturing about the 'problem' of migration.

This study sought to answer the following questions:

1. How is migrant health conceptualised by PHPs?
2. What are the perceived societal, policy and institutional contexts of migrant health?
3. How do PHPs address migrant health in current practice?
4. What are the perceived strengths and gaps in public health practice relating to migrant health?

Methods

Study design, sampling and recruitment

The study adopted a qualitative design to elicit the views, understandings and complexities of PHP's views of migrant health issues. A purposive sample of 14 PHPs working at Public Health England (PHE) or local authorities across an English region was recruited by email invitation, circulated by their Director of Public Health or Deputy Director of Centre. To be eligible, participants had to be senior PHPs working for the regional main employers, namely, the Public Health England (PHE) regional office or local authorities. Senior PHPs were defined as professionals working at agenda for change band 7 or above (or equivalent). It was important that participants were experienced enough to have in-practice knowledge of both the regional public health terrain and the location of migrant health within that over time. The study was designed to include focus groups and interviews. These mixed methods were used as a way of eliciting as much rich data as possible on, what is, a controversial topic that might carry risks of participant discomfort and professional reputational damage. As such, participants had the option of taking part in a group discussion or a one-to-one interview. Semi-structured interviews with ten participants and one focus group with four participants were conducted using a standardised and piloted interview/focus group discussion guide. Data collection continued until data saturation was reached.

Data collection and data analysis

Data collection was conducted at participants' place of work in the summer of 2017. The focus group and interviews were recorded with participants' consent. Recordings were transcribed verbatim.

Thematic analysis was conducted following the process of data familiarisation, code generation, searching for themes and reviewing them, defining themes and write-up identified by Braun and Clarke (2006). A combined deductive and inductive approach was used to analyse data. Themes were structured around the broad content of the fieldwork questions

with inductive themes added through the process of data analysis. NVIVO 11 was used to assist with data management, coding and analysis. This first author undertook coding of the dataset in NVIVO 11 which was reviewed by the second author. Any discrepancies in coding and theme generation were discussed and resolved between the two.

Ethics

Ethical approval and research governance was obtained from the School of Health and Related Research, University of Sheffield (ethical approval number: 012907). The identities of all participants have been protected by anonymising the data.

Results

The study uncovered four main themes of discussion: i) The problematic nature of migrants and migration, particularly after the Brexit vote; ii) The ways in which migrant health was currently formulated in public health circles; iii) How public health could better address migrant health issues; and, iv) the gaps in current public health practice relating to migrant health.

i) The problematic nature of migration and migrants

Migration was recognised as a politically 'hot' issue. This made approaching the topic of migrant health contentious and professionally challenging. Migration was the subject of negative social discourse that created a difficult backdrop within which to work:

> I just think those interactions with professionals are preloaded by a [the idea that] 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, there's a...there's just a negative bubble I think around it at the moment (Participant ID 9, PHE)

This was particularly evident after the British referendum to exit the EU in 2016. Respondents felt the result of the vote implied the UK had rejected a welcoming environment for migrants and PHPs felt the topic had become 'toxic' and, hence, difficult to act within. Public Health Professionals identified this was signified by the normalisation of racist discourse in the national news; negative narratives among politicians and worrying everyday interactions between workplace staff that signified intolerance (e.g. anonymous racist graffiti in workplaces; migrant groups being inappropriately highlighted in 'alerts' being sent between health professionals). Respondents identified this all served to influence the workforce and erode trust between communities and PHPs trying to promote good health among migrants. It also created a 'hyper-sensitivity' around issues of migration and ethnicity with some PHPs reporting feeling nervous about what language/terminology to use, how to present their work to senior colleagues and concerns that taking on the topic of migration could be career-damaging. One respondent noted that the topic was so sensitive that a PHP with a minority ethnic background had asked White British colleagues to present their work, as it was more likely to be received in a positive way.

> [Name], has an Asian background and is married to a [religious affiliation] man. She would say, "if you say that it will be heard differently than if I say that" … There is something about a belief that if they say it, it is being seen as just someone standing up for minority rights rather than it being on the basis of evidence and health. That's a conversation that we have had since the Brexit vote. It's not a conversation we have had before. (P7, PHE)

> [Name], Chinese background…[specific project]…has been working with [name] who is from a Hindu Indian background. 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. (P7, PHE)

Mindful of this backdrop, PHPs nevertheless had a formulation of what it meant to be a migrant in the UK. Narratives centred issues of limited resources, vulnerability and risk, particularly in relation to sex abuse, drug abuse and exploitation. Additionally, respondents recognised that migrants were exposed to discrimination and disadvantage. Public health professionals particularly referenced how migrants were disadvantaged in the health system. This was, in part, owing to their lack of knowledge about how to access services, especially primary care. Low health system understanding also combined with discrimination within health services to reduce proper access:

> I think within the health service itself there will be a proportion of people who don't feel migrants should have the same access to the service that 'true Brits' do, because of the way that we're set up culturally (P4, PHE)

It was notable that these understandings were rarely informed by direct experience of working with migrant populations; this was a supposition of vulnerability. Professionals sometimes noted the diversity of migrant populations and commented on how this could also be problematic when seeking to identify health needs:

> 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. (P13, Local Authority)

There was no commentary, however, on how some migrants may arrive in the UK in advantaged circumstances (e.g. professional employees migrating for work and with private health insurance).

ii) How migrant health was formulated in public health professional discourse

In the context of assumptions of vulnerability and in a climate of hostility to migrants, PHPs framed migrant health in a health inequalities discourse. Respondents highlighted the impact of the wider determinants of health (e.g. housing and employment) on migrants:

> The determinants of health just don't marry up in a lot of places, so transport, employment are a real issue and I think people haven't still got a grasp of, because we're so removed from how public health works, we're still pushing agendas like attendance of screening programmes and things, when actually for a lot of people it might be the decision to buy a can of beans or get on a bus (P17, Local Authority).

This comment highlights how PHPs were concerned that migrants were unable to meet basic needs to support good health. Those working within local governments felt somewhat empowered to make a difference at the local level whereas those in PHE discussed feeling removed from communities and thus unable to affect change.

Some PHPs described the health beliefs of migrants were different to those in the rest of the region. How beliefs differed was, however, less clear. Respondents reported a lack of knowledge of different health beliefs and behaviours but commented on how action to, for example, raise awareness of specific health issues among migrant populations was futile.

> 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 (P14, local authority).

This was underscored by an assumption that health issues were a relatively low priority for migrants because newly arrived groups had other, more basic, or urgent needs to be met. This low knowledge base (or confidence in it) combined with a negative social and vulnerability discourse served to effectively paralyse positive action in this field, despite the recognition that this left new arrivals underserved and at risk of avoidable health disadvantage.

iii) How public health could better promote migrant health: opportunities and challenges

Many felt that migrant health was not adequately addressed in current public health practice. Respondents reported a desire to see migrant health as a clearer national priority. This would help legitimise local action. One respondent noted: "I do think it's easier to do that [work to promote migrant health] when you're getting that direction from the top as well as it coming up from the ground" (P17, PHE). Respondents felt prioritisation of migrant health had been negatively impacted by the post-2013 fragmentation of the health system. They noted this had required them to focus on relationship building and bridging between organisations in a way that felt they were 'starting from scratch'. This was magnified by the fact that public health work focussing on migrants was the domain of multiple statutory and non-statutory services (e.g. charities and local community organisations):

> I think the way that everything is so fragmented, and it's really, really difficult to get anything done. To get even the smallest thing done it feels like a real uphill struggle sometimes because everything is so… you need to involve so many different people (P18, PHE).

PHPs wanted to develop practice through a community focus that created a voice for migrants, to assist in efforts to improve social integration such as to promote understanding between communities. Building trust between public health and migrant communities was a key area of focus, as well as supporting staff to be resilient when met with resistance to their work, either from institutions, colleagues or the community. Whilst PHPs displayed clear intent, the mechanism for achieving these aims was less clear, with a single suggestion for sharing more stories with the public that tell the story of migrants. Role modelling behaviour and ensuring zero tolerance to unacceptable, especially racist, views was suggested as a key

priority for public health management, to enable them to provide an arena for PHPs to express their concerns and emotions about the uncertain and highly politicised environments in which they are working.

Participants wanted to focus work on asserting that the NHS is free for all, to overcome some of the impact of Brexit. This was, however, complicated by the change to the NHS Charging Regulations 2015. Under these new rules, many overseas visitors are charged up-front for secondary care that is not urgent or immediately necessary. This created a complication in generating a clear and positive narrative about good access to care in the UK.

The extent to which PHPs engaged in a future positive vision for migrant health was moderated by the social and institutional challenges described. These challenges included: a lack of incentives for organisations and providers to improve migrant health; no senior voice or advocates for migrants in health organisations; low priority placed on migrant health; professional insecurity and conflict about how best outcomes could be achieved; ignorance of migrant health needs and layers of bureaucracy that meant change was slow and difficult. To overcome these issues, PHPs reported attempts to get leadership level buy-in but felt frustrated by a lack of influence in their organisations, particularly on issues relating to migrant health and inequalities.

Another major institutional issue described was a lack of resource. This was not only financial, but also a lack of people. Respondents noted being unable to attend conferences and other learning opportunities due to lack of funding. Their role had changed from a budget holding role, to be one of influencing and priority setting that they felt lacked impact. They described being good at doing "more with less" and the necessity of identifying the non-monetary incentives to their partners, stakeholders and providers to ensure that action to improve migrant health took place.

Respondents used several strategies to champion migrant health issues and reduce inequalities in general, for example: raising the issue of inequity and reminding people of their inequality reduction duties; negotiating with external organisations; working to repurpose resources for improved outcomes; accepting a trial-and-error approach to working with communities; ensuring effective communications with partners to keep people engaged; developing relationships with community leaders, groups and representatives; acknowledging different perceptions and presenting evidence to overcome these; getting and keeping leadership buy in; focusing on communities to make work community-centred and asset-based; sharing learning; using data to influence senior leaders and focusing on increasing GP registration.

One PHP described how they use the societal context and political situation to their advantage by using local and national interest in migration to influence change.

> I always find it helpful to come back to the definition of public health which is about the science and the art…So, the science of public health definitely remains the same when you are talking about new migrants or when you are talking about any group…but the art of how you take that science to affect change definitely is impacted by the politics, the partners, who's in power, the national rhetoric, the national policy, the national strategy (P13, local authority).

iv) Gaps in public health practice relating to migrant health

A number of gaps were identified by PHPs, the most pertinent of these being a lack of knowledge of health needs and cultural difference. PHPs were not sure how to support community integration, how to increase GP registrations or how to reach those who were underserved. Some PHPs felt that they were not able to keep up to date with evidence and

applicable training due to resource constraints. PHPs believed that it was important to have experienced and appropriately trained public health practitioners that had achieved appropriate competencies in this area. Whilst the varied backgrounds of PHPs is celebrated, it is felt that there is no consistency in their training and skills, due to no mandatory requirement for practitioner registration.

Respondents noted a lack of ethnic diversity in the public health workforce and many PHPs described the unmet need to recruit from the communities they served. PHPs required legitimised time to understand migrant health issues and remain up to date with evidence. Several felt that such legitimisation coupled with a clear vision, advocacy and top down support both locally and nationally could allow a shift that makes migrant a health a priority in public health.

PHPs also felt that high quality community engagement that went beyond 'tick-box' exercises was absent in this field. In addition, the ability to evaluate complex interventions and demonstrate impact was lacking, either through return on investment or other economic evaluation. Without this, it was difficult to make a case for local action.

Discussion

This research starkly highlights the ways in which migrant health is framed by public health professionals and the multiple ways it is under-addressed in current practice. This represents a serious concern for public health practitioners in England and resonates strongly with research in other spheres, such as primary care and health service commissioning (23,24). Negative social discourses, institutional barriers and personal confidence and competences conspire to ensure migrant health is a low priority for public health action, despite recognition that this leaves new arrivals at risk of avoidable health disadvantage.

The notion that migrant health is 'too hard and complex' reflects strongly the findings on ethnicity in health service commissioning in England by Salway et al (24–26). Salway found that attention to ethnic diversity and equality was often marginalised during NHS commissioning processes as a result of ambivalence (and sometimes active resistance) among senior leaders. Lack of clarity in policy about expectations resulted in lack of confidence for practitioners who felt ill-equipped to undertake work perceived as sensitive. This is mirrored in this research, with PHPs feeling clearer policy directives would legitimate local action to improve migrant health. Those who do feel able to take action to improve migrant health experience difficulty in knowing how to act, with some feeling that small and manageable steps should be taken, and others feeling that they must fully understand the situation and 'need' before taking action.

This research is the first of its kind with PHPs since the restructure of the health system in 2013 and after the referendum for Britain to leave the EU; a time of institutional transition and deep social unease about migration in the UK. It offers both cause for concern but also multiple opportunities for change. Importantly, the finding that PHPs view migrant health mainly through a health inequalities lens offers the opportunity to better integrate issues of migrant disadvantage into public sector action to reduce social and health inequalities. There is also a danger, however, that the positioning of all migrants as 'vulnerable' serves to reinforce stigmatising social narratives about migrants being a burden on public services. Broad brush stereotyping may be constraining action in this area. It is advisable that public health and other health sector professionals are offered educational opportunities to critically reflect on what it is to be a 'migrant' in the UK.

This research reflects the wider literature on the challenges of public health engagement in migrant health in terms of: funding (27–29), new legislation (30–32), fragmented systems (33,34); time pressures (30,35); uncertainty and lack of understanding of migrant health

needs (26,33,36–38); the tendency to stereotype migrant groups (35) and feeling that all groups should be treated equally rather than equitably (fear of favouring one group over another) (17,26). It is notable, however, that participants clearly identified migrant health as an issue that went beyond communicable disease control and management. This offers an opportunity to expand current public health guidance and thinking that recognises migration as a wider determinant of health. These emergent perspectives that account for the 'whole person in context' are being trailblazed in some areas of primary care and offer much promise for the future direction of public health (23).

Limitations

This research was conducted in a regional context in England. While it is feasible these findings represent broader PHP experience, we do not claim generalisability. Bias may have been introduced owing to some respondents being known to the first author and through the endorsement of the work by Director-level professionals in recruitment.

Conclusions

This research is the first of its kind since the restructure of public health in England in 2013 and the decision for the UK to leave the EU in 2016. We have described how PHPs conceptualise, frame and understand migrant health, primarily as a legitimate but problematic field of public health concern. This is specific to the prevailing, and hostile social, political and, policy contexts. It is unsurprising, therefore, that PHPs approaches to addressing migrant health are characterised by frustration and wariness. PHPs in this study group were, however, cognisant of apparent gaps in public health practice related to migrant health and had some promising ideas that require examination in future work. In particular, this exploratory work revealed that PHPs perceive a lack of knowledge on migrant health needs and cultural difference; a lack of access to appropriate training; a lack of cultural diversity within the PH

workforce; and the need for meaningful community engagement as opportunities to engender change and improve the health of migrants living in the populations they serve.

Future research could build on this work by examining these expressed desires of PHPs more completely, among a wider group and across broader geographies. In addition, partner organisations in the public health area such as primary care, secondary care trusts, CCGs and NHS England require engaging to further agendas on the reduction of health inequalities and best promote the future health of migrant populations.

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Competing interests

None.

Ethical approval

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