Migrants from Eastern Europe
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Summary

Migrants from Eastern Europe introduction

- The exact boundaries of Eastern Europe are not well defined and each nationality has its own identity, culture and language.
- At the 2011 Census, Poles were overwhelmingly the largest group of Eastern Europeans in Suffolk. The next largest was Lithuanians; these two nationalities, together with Latvians and Romanians (the next two most numerous), made up 79% of Eastern Europeans resident in the County.
- In Suffolk, Ipswich has by far the highest number of Eastern Europeans, followed by St Edmundsbury and Forest Heath. Both Ipswich and Forest Heath had a higher proportion of residents from Eastern Europe than the East of England and England as a whole.
- The predominance of Poles is corroborated by an analysis of main language as reported in the Census. Polish was also the most common non-English language spoken as a mother-tongue in Suffolk schools.
- The majority of Eastern European people in Suffolk are young adults of working age. There are also children and some middle-aged and older people. The pattern with Romanians is similar to that seen for Poles, but is less pronounced.
- In the five years to 2013, the rate of inward migration to Suffolk was broadly constant.
- The number of non-UK nationals working, planning to work legally or claiming benefits in Suffolk is consistently lower than elsewhere in the region or in England.

Migrants from Eastern Europe key points

The main health problems for Eastern European migrants include:

- Mental health problems. The main mental health problems facing economic migrants are loneliness, anxiety and depression, along with the effects of excessive drinking.
- Obesity. Central and Eastern European countries have a higher prevalence of obesity than those in Western Europe, especially among women. Eastern European populations have had a particularly high mortality rate from cardiovascular disease
- Sexually transmitted infections. Migration is associated with the ending of previous sexual relationships and the establishment of new ones. It can lead to high-risk sexual behaviour, so migrants from Eastern European countries are at an increased risk of developing sexually transmitted disease
• Drug and alcohol consumption. Excessive drinking and the use of illicit drugs are reportedly common amongst Eastern European men. Alcohol specifically is a major cause of ill-health in the Eastern European region, with binge drinking a special threat.
• Smoking. Eastern European countries have high rates of smoking. In consequence, lung cancer incidence is higher there. Migrants to the UK have higher rates of smoking.
• Poor housing. Many economic migrants lack access to good housing advice, often due to language barriers, uncertainties about entitlement and the opening hours to the services.[21] They often occupy poorer quality private rented housing.
• Lower understanding of the British health system. Migrants often lack knowledge of the UK health system and specifically of the role of the general practitioner (GP) and primary care.
• Barriers to accessing healthcare. Limited English, rural locations and lack of GP registration can make it harder for migrants to use the NHS.

Migrants from Eastern Europe recommendations

1. Health messages should be available in appropriate languages and visible in areas that are accessed by the Eastern European population.
2. Services, particularly stop smoking, Drug and Alcohol, mental health and sexual health services, should be able to meet the needs of Eastern Europeans' taking account of their culture, language, and lifestyle.
3. The formation of social groups should be encouraged to reduce social isolation which is a problem particularly for young, single males.
4. Eastern European migrants need access to appropriate housing advice.
5. Improving the understanding of migrants about local health and care systems including GP registration, self-care and referral to secondary care, would promote appropriate use of health and care services and also improve access to services.
6. Ensure professionals in all services understand how to access translation and interpretation services, and that they are widely available. This should decrease the practice of children and others interpreting for family members or friends, when personal information is being discussed.
7. Use contracts to strengthen the collection of ethnic group data, to enable better understanding of the health and well-being needs of local communities.
Which migrants from Eastern Europe live in Suffolk?

When the term Eastern Europe is used it at its simplest means countries in the eastern part of the European continent. It is often taken to mean the countries which were under communist rule until the end of the Soviet Union. However, the exact boundaries of Eastern Europe are not well defined (see Appendix A).

In this report, we mostly discuss Eastern Europeans as a single group. However, this is a simplification; each nationality has its own identity, culture and language. Some Eastern Europeans would prefer not to be labelled in that way, just as British people might not see themselves as Western Europeans.

Migrants to Suffolk do not come equally from all of the countries in Eastern Europe. Table 1 shows the countries of origin of the 11,220 respondents to the 2011 Census in Suffolk who gave countries of origin in Eastern Europe, as defined as present in at least one of the lists in the Appendix A.
Poles were overwhelmingly the largest group, constituting 54% of the total. The next largest was Lithuanians (13%). These two nationalities, together with Latvians and Romanians (the next two most numerous), made up 79% of Eastern Europeans resident in the County on Census night. In England as a whole, Poland (8.7%) is among the top three countries of birth for foreign-born individuals in the UK, along with India.
(9.1%) and Pakistan (5.8%). Poland represents the largest proportion of foreign-born people living in the UK who have retained their original nationality, with 14.9% of the total (Office for National Statistics, 2013).

Table 2 shows the number of these four most frequent nationalities in each local council district in Suffolk and for the County as a whole. Ipswich has by far the highest number of Eastern Europeans, followed by St Edmundsbury and Forest Heath. Both Ipswich and Forest Heath had a higher proportion of residents from Eastern Europe than the East of England and England as a whole; this was 2.1% in both cases.

Table 2: Numbers of migrants from Latvia, Lithuania, Poland, Romania and total Eastern European, by local authority, Suffolk, 2011

<table>
<thead>
<tr>
<th>Local authority</th>
<th>Latvia</th>
<th>Lithuania</th>
<th>Poland</th>
<th>Romania</th>
<th>Other Eastern European</th>
<th>Total Eastern European</th>
<th>Total Eastern European as a proportion of overall population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Babergh</td>
<td>44</td>
<td>24</td>
<td>330</td>
<td>42</td>
<td>149</td>
<td>589</td>
<td>0.7</td>
</tr>
<tr>
<td>Forest Heath</td>
<td>79</td>
<td>194</td>
<td>1204</td>
<td>66</td>
<td>334</td>
<td>1877</td>
<td>3.1</td>
</tr>
<tr>
<td>Ipswich</td>
<td>399</td>
<td>837</td>
<td>2367</td>
<td>219</td>
<td>838</td>
<td>4660</td>
<td>3.5</td>
</tr>
<tr>
<td>Mid Suffolk</td>
<td>35</td>
<td>56</td>
<td>223</td>
<td>46</td>
<td>111</td>
<td>471</td>
<td>0.5</td>
</tr>
<tr>
<td>St Edmundsbury</td>
<td>74</td>
<td>189</td>
<td>1266</td>
<td>79</td>
<td>448</td>
<td>2056</td>
<td>1.9</td>
</tr>
<tr>
<td>Suffolk Coastal</td>
<td>45</td>
<td>108</td>
<td>377</td>
<td>104</td>
<td>308</td>
<td>942</td>
<td>0.8</td>
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<tr>
<td>Waveney</td>
<td>14</td>
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<td>339</td>
<td>96</td>
<td>132</td>
<td>625</td>
<td>0.5</td>
</tr>
<tr>
<td><strong>Suffolk</strong></td>
<td>690</td>
<td>1452</td>
<td>6106</td>
<td>652</td>
<td>2320</td>
<td>11,220</td>
<td>1.5</td>
</tr>
</tbody>
</table>

Source: Office for National Statistics, 2011 Census
Figure 1 shows the proportions of the Suffolk population from these four nationalities. Although numbers of Eastern Europeans were higher in St Edmundsbury than in Forest Heath, the lower total population of the latter local authority means that they represent a higher proportion of residents.

**Figure 1: Proportions of population from major Eastern European nationalities, by local authority, Suffolk, 2011**

![Proportions of population from major Eastern European nationalities](image)

Source: Office for National Statistics, 2011 Census

The predominance of Poles is corroborated by an analysis of main language as reported in the Census. After English, Polish was overwhelmingly the most common main language, used by 5762 people. The next most common was Lithuanian, used by 1275 people. No other main language was reported by more than a thousand people.

In more recent data from 2014, Polish was also the most common non-English language spoken as a mother-tongue in Suffolk schools, with 1146 speakers. Lithuanian with the third most common, with 397 schoolchildren, after Portuguese with 679 schoolchildren (Office of National Statistics, 2014).

More detailed analysis is available for the Polish and Romanian population of Suffolk. Figures 2 and 3 show the age structure in 2011 of Suffolk residents born in Poland. The analyses for males and females show a similar pattern, with the majority of people being...
young adults of working age. There are also children and some middle-aged and older people.

**Figure 2: Age structure of males born in Poland and resident in Suffolk, 2011**

![Age structure chart]

Source: Office for National Statistics, 2011 Census
Figure 3: Age structure of females born in Poland and resident in Suffolk, 2011

Source: Office for National Statistics, 2011 Census

Data on Romanians in Suffolk are only available for Ipswich Borough because of small numbers elsewhere. The pattern is similar to that seen for Poles, but is less pronounced: there are proportionately more children of school age and middle-aged adults (Figures 4 and 5).
This needs assessment was prepared in July 2015 by the Public Health Action Support Team on behalf of Suffolk County Council.

**Figure 4: Age structure of males born in Romania and resident in Ipswich, 2011**

Source: Office for National Statistics, 2011 Census

**Figure 5: Age structure of females born in Romania and resident in Ipswich, 2011**

Source: Office for National Statistics, 2011 Census
We found no other data specific to Eastern Europeans in Suffolk. However, there are broader indicators of inward migration which are relevant. Figure 6 shows three indicators for the five years to 2013, the most recent year for which data are available. They suggest that the rate of inward migration to Suffolk was broadly constant over this period. The rate may have risen after Bulgarians and Romanians gained the right to work in the UK in 2014.

Figure 6: Migration indicators, Suffolk, 2009 to 2013

![Graph showing migration indicators from 2009 to 2013.](chart)

**Source:** Office for National Statistics

NINo: The number of new National Insurance Numbers (NINos) registered by migrants in the UK provides an indication of the number of economically active foreign nationals entering the country. NINos are issued to all non-UK nationals aged 16 or over working, planning to work legally or claiming benefits in the UK, regardless of how long individuals intend to stay. Figure 7 compares the rates of new National Insurance Numbers (NINos) registered by migrants in Suffolk, the East of England and England as a whole for the same five year period. It indicates that the number of non-UK nationals working, planning to work legally or claiming benefits in Suffolk is consistently lower than elsewhere in the region or in England. NINo data do not indicate the number of people who may have registered elsewhere before coming to Suffolk.
What are the health problems for Eastern European migrants?
We reviewed the literature to identify the most important health problems affecting Eastern Europeans resident in the UK. The answers are not always clear-cut, because the research may not be focused on migrants of the same nationalities as are seen in Suffolk, may be concerned with groups defined by ethnicity not nationality, or may be in settings which are dissimilar to Suffolk. However, their general conclusions are likely to be relevant (Tobi et al, 2010, Centre for Public Health 2014, City of Bradford 2014).

Many migrants from Eastern Europe have good health, and the worst health problems are concentrated in a small minority.

Mental health
Research on the mental health of migrants to the UK is largely concerned with asylum seekers and refugees. Eastern European communities in the UK are however known to have poor mental health, attributable to a combination of underlying risk, experiences in migrants’ home countries and the stresses of immigration and of adaptation to and living conditions in the new country (Tobi et al 2010, Patel 2012, Lindert et al 2008). Migrants from Eastern Europe may be socially isolated and vulnerable, for example living in multiple occupancy.
houses, which can exacerbate mental health problems. Paradoxically, those with the greatest needs are therefore least likely to use services.

The main mental health problems facing economic migrants are loneliness, anxiety and depression, along with the effects of excessive drinking (Moore 2007).

**Obesity**

After the end of communist rule in Eastern Europe, a high fat and high sugar diet became more common (Webber 2012). Alcohol consumption also rose substantially. As a result, Central and Eastern European countries have a higher prevalence of obesity than those in Western Europe, especially among women. Eastern European populations have had a particularly high mortality rate from cardiovascular disease (Rabin et al 2007).

**Sexual health**

Sexual health is an important issue for migrants from Eastern Europe:

The collapse of communism was followed by a marked deterioration in public health services, including the surveillance and treatment of sexually transmitted infections. Awareness of these illnesses and of their consequences are low, and antibiotic resistance is high in Eastern European countries. The use of intravenous drugs and needle sharing also contributed to a high prevalence of HIV infection (EuroHIV, 2007).

Migration is associated with the ending of previous sexual relationships and the establishment of new ones. It can lead to high-risk sexual behaviour, so migrants from Eastern European countries are at an increased risk of developing sexually transmitted disease (Patel 2012, Burns et al 2008). Eastern European migrants, especially males, report high rates of risky behaviours associated with increased transmission of HIV and other sexually transmitted infections; these include excessive alcohol consumption, recreational drug use, anal sex and paying for sex (Burns et al 2011).

Migrants often have limited knowledge and experience of the British health systems. This means that they may access services late or not at all, and not take up contact-tracing opportunities (Tobi et al 2010). Eastern European women are more likely to attend genito-urinary medicine clinics than their male counterparts (Burns et al 2008).
There is less cultural acceptance of homosexuality in some Eastern European societies. Lesbian, gay, bisexual and trans-gendered people face stigma and discrimination and may therefore emigrate to a more tolerant society (Burns et al 2008).

Drugs and alcohol

Excessive drinking and the use of illicit drugs are reportedly common amongst Eastern European men. Alcohol specifically is a major cause of ill-health in the Eastern European region, with binge drinking a special threat (Bobak et al 2004, Nemtsov 2002, Bunting 2010). People from Poland and the Baltic states are said to drink more than those from Romania and Bulgaria. Needs assessments have reported higher rates of alcohol use in migrant populations (Patel 2012); however, an analysis of alcohol-related hospital admissions in the UK found no excess of people of Polish origin (Collinson et al 2010).

Alcohol dependency is linked to homelessness and is a significant health problem amongst the homeless Eastern European population in London (Haringey 2014). In Haringey, Eastern Europeans form part of the visible street-drinking population, and a street outreach programme is in place to target individuals from Poland and Eastern European communities (Malvezzi et al 2013).

Smoking

Eastern European countries have high rates of smoking (Moore 2007). In consequence, lung cancer incidence is higher there, with rates of 55 to 80 per 100,000, compared with rates in Western Europe of 35 to 40 per 100,000 (Eida 2010).

Migrants to the UK have higher rates of smoking than the indigenous populations (Patel 2013). Most started smoking before coming to the UK, with prevalence highest in those in routine and manual jobs or with weaker language skills (Eida 2010).

This is compounded by language difficulties. Smoking cessation services involve counselling which depends on linguistic compatibility between the smoker and the advisor. Migrants are therefore unlikely to use or benefit from smoking cessation classes conducted in a language in which they are not proficient; there is evidence that this deters people from accessing mainstream services (Eida 2010). To overcome this, smoking cessation classes have been organised in some places with the local Polish Society – an example of this is Crewe (Webber et al 2012, Kofman et al 2007).
Housing
Overcrowded, poor housing damages health. Many economic migrants lack access to good housing advice, often due to language barriers, uncertainties about entitlement and the opening hours to the services (Kofman et al 2007). They often occupy poorer quality private rented housing (Shelter 2008, Ricketts 2008, Spencer et al 2007). If their employment is linked to their accommodation, the disadvantage from poor housing can be compounded by excessive working hours (Ricketts 2008). Agricultural work is sometimes seasonal, leaving migrants not only unemployed for part of the year, but also without accommodation.

Understanding of the British health system
Migrants often lack knowledge of the UK health system and specifically of the role of the general practitioner (GP) and primary care (Tobi et al 2010, Lindert et al 2008, Collis et al, 2010). This affects what they expect from services and how they use them (Duckworth et al 2012). Those with fluent English tend to have more understanding of the NHS (Collis et al 2010).

Lack of information can lead to inappropriate use of services. For example, some Eastern European patients attend emergency departments because they do not understand the UK health system and may find it hard to register with a GP because of language difficulties (Webber et al (2012). There is conflicting evidence about migrants’ registration with and use of primary care (Duckworth et al 2012). Those unregistered cited lack of knowledge about the process, lack of need or inclination and language as the main obstacles (Tobi et al, 2010). Some researchers have suggested that migrants need information on health services when they enter the UK (Collis et al 2010).

This lack of understanding of the system can lead to dissatisfaction and frustration with the UK health system. In many Eastern European countries, patients consult specialists without referral from a GP. They may be used to direct access to hospital services and a lower threshold for investigations than in the UK – for example, more scans in pregnancy (Webber et al (2012). The concept of a GP as a gatekeeper to other services is unfamiliar, and may be experienced as a denial of care or cost-saving manoeuvre.

There are also different expectations about prescribing and availability of medicines, which may be due to variations in the health care systems in participants’ countries of origin (Duckworth et al 2012). Many Eastern European women believe that they cannot access
any gynaecology services without referral to a specialist by the GP, including genito-urinary medicine and contraception services.

A London GP provided an anecdotal account of her experience of Polish patients (Greenhalgh, 2006). They believed that, compared with Britain, GPs in Poland take illness more seriously and make more specialist referrals, postnatal care continues for longer periods and sick children can access a paediatrician immediately as opposed to having to wait for several weeks. Her experience was that Polish immigrants brought with them “memories of a healthcare system in which general practice is often the last refuge of the failed physician”.

Some Eastern Europeans choose not to use NHS services, but instead consult doctors from their country privately, or return there for dental care or other forms of treatment. This is more consistent with their previous experience of unmediated access to specialist care, and may provide culturally and linguistically accessible healthcare. After returning to the UK, they may develop complications which require treatment here. However, some of these patients may not have full knowledge of what NHS services are available and why, or may be deterred by concerns about the availability of an interpreter; with better information, they might make more use of the NHS.

**Barriers to accessing healthcare**

Limited English is a significant barrier to Eastern Europeans making use of the NHS. We were not able to obtain any data on the language proficiency of migrants in Suffolk, and language skills tend to improve with time spent in a new country. However, there are anecdotal reports of the inadequate availability of interpreters. Language Line is an NHS interpretation service available in Suffolk, but it is not adequately publicised and in some cases we were told that it is used inappropriately. INTRAN provides translation services at West Suffolk Hospital and TIP does so for the marginalised and vulnerable adults service. Some Eastern Europeans live in remote rural locations with limited public transport. Some work long hours. These are also barriers to use of services, including the NHS.

Entitlement to health care and benefits depends on migration status (Jayaweera 2010). Eastern Europeans are not always aware of their entitlements. The proportion who hold this card is 5% to 10% (Jayaweera 2010). Cultural insensitivity and associated taboos (for example sexuality and domestic violence) means that it is often difficult to discuss these issues with Eastern European patients, especially for women consulting a male practitioner.
This needs assessment was prepared in July 2015 by the Public Health Action Support Team on behalf of Suffolk County Council.

(Tobi et al 2010). We heard that only one in five migrants from Eastern Europe known to Migrant Help, a charity which assists migrants, is registered with a GP. Some do not access NHS services or register with a GP because they believe that a fee would be payable. From 2016, the introduction of the habitual residence test may reduce access to some NHS services for migrants who lose recourse to public funds.

Accessing mental health services is particularly difficult. Ethnic minorities and migrants may be affected by

- different understandings of mental health problems
- lack of acknowledgement and discussion of, and priority for, mental health problems
- lack of knowledge of services
- stigma, fear of authority and lack of trust
- previous negative experiences of accessing NHS services
- lack of interpreting and translation services

In Suffolk and elsewhere, many migrants from Eastern Europe work in agriculture and food-processing in rural areas. This is different from previous waves of immigration, where newly arrived people were concentrated in cities. Healthcare resources may be more thinly spread in rural areas, less flexible and with fewer resources to accommodate specific needs. There are also poor health and safety practices in some industries which employ migrants. Occupational health arrangements are often limited or absent, staff do not usually have union representation and may be engaged via an agency rather than directly employed.

**Suffolk County Council’s survey in 2010**

In 2010, Suffolk County Council published a survey of migrants (Suffolk County Council 2010). It was based on 400 face-to-face interviews. Two hundred and eight of the respondents were Polish and most of the rest were Eastern European. Although the survey is no longer current, it corroborates and reinforces many of the findings of this report.

In the 2010 Suffolk survey, 88% of migrants rated their health as good or very good. This compared to 76% of the adult population in Suffolk.

Overall, 18% of migrants had not used primary care, 42% had not used a dentist and 34% has not used a local hospital. Of those that had used these services, 88% were at least satisfied and 8% dissatisfied with primary care, 73% were at least satisfied and 6%
dissatisfied with dentist services and 76% were at least satisfied and 5% at least dissatisfied with their local hospital.

Eighty per cent of migrants in this survey had registered with a GP. Lithuanians were less likely to be registered (59%). There was also some variation by district, with 61% registered in Babergh and 91% registered in St Edmundsbury. Fifty-one per cent of those who had been in the UK for under a year had registered with a GP, compared with 91% of those that have lived here for over a year.

What is the pattern of services in Suffolk at present?

General health services
Eastern Europeans have access to the full range of local health services.

We wished to analyse routine NHS activity datasets to understand in more detail patterns of utilisation of Eastern European residents of the County. However, the ethnicity data groups all Eastern Europeans into the “any other White” category, along with all White patients not categorised as British or Irish. This group will include other European migrants and residents in Suffolk, as well as White people from North America and Australasia. It is therefore not helpful for the present analysis.

Specific services
The Marginalised and Vulnerable Adults (MVA) service (Health Outreach Project) runs health outreach throughout East and West Suffolk, offering a drop-in service for people from marginalised and vulnerable groups. It is not commissioned for the population of Waveney. The service offers immediate help, and signposts people to GPs and other services. The service’s database is a potentially rich source of information about the health needs of users, including people from Eastern Europe, and about how those needs are met. It records service users’ ethnicity. Unfortunately, the database could not be analysed for this project. We were told that two to three Eastern Europeans attend the service each day, and that there are about a dozen Eastern Europeans among the homeless people known to the service.

Migrant Help is a charity which assists migrants by providing resources and support to find safety, access appropriate services and information, develop greater independence and become successful, active and contributing members of the community. Funded by the Big Lottery until September 2015, it provides services in Ipswich, Newmarket and Brandon. It is not clear whether it can continue after this grant ends.
Keystone Development Trust aims to build community capital by empowering individuals, groups and communities to tackle needs and issues by creating their own solutions, organisations or enterprises. It numbers Eastern Europeans among the groups it supports.

We held a focus group with a senior manager from Migrant Help and the Keystone Development Trust.

**What is the evidence base for interventions? What is best practice?**

We searched for evaluated interventions aimed at improving the health and wellbeing of Eastern European populations in the UK. We found one which had been subject to evaluation. The Smokefree Northwest project developed a service in Central and Eastern Cheshire aimed at smokers in the Polish community in Crewe (Eida et al 2010). It was based on a mainstream smoking cessation model, but with language-related adaptations to suit the target audience.

The evaluation showed that the service was successful. Sixty-five people accessed the service, with a 40% quit rate achieved. Ninety per cent of service users said that they would recommend the service to a friend. Most service users became aware by word of mouth; referrals from health service providers and self-referrals from paper and internet publicity were low.

There are other examples of projects which indicate the approaches taken elsewhere. Although they have not been evaluated, they are still of interest:

- The Highland region of Scotland has a Polish community of 4,500. NHS Highland provided leaflets in Polish and translators were available at clinics attended by large number of Polish people. The leaflets covered topics specific to pregnant Polish women, such as routine blood and screening tests, which may not be familiar from the Polish healthcare system. This intervention received positive feedback (Moore et al 2007).
- NHS Scotland’s website describes the Scottish health service and how to access it. It is available in different languages and covers subjects from the need to register with a GP to where to go for marriage guidance.
- In Norfolk, a former primary care trust commissioned an interpreter to run sessions at GP surgeries. Medical practices had access to a communicating/interpreting service and frontline healthcare staff, were given language cards so migrants could point to the language that they speak (Moore et al 2007).
• This primary care trust held a Migrant Workers Day to provide advice on diet, lifestyle, sexual and mental health, and social care. The feedback from the migrant community led to changes in the Trust’s service-level agreements with providers to help ensure migrant workers receive appropriate care (Moore et al 2007).

• In Reading, the former primary care trust worked with local agencies, including the Catholic Church, to inform the Polish community about the health system. It also used health advisers from within the community, based on a scheme developed with its local black and minority ethnic community (Moore et al 2007).

What additional information is needed?
It was disappointing that the MVA service’s dataset was not available for analysis. The dataset needs to be analysed so that its value for health needs assessment and service evaluation is fully realised.

More generally, the recording of ethnic and nationality data is far from complete in the NHS. It may not be practical to record data showing details of national origin in every case, but the absence of any data constrains what can be learned of the use which Eastern Europeans make of services.

What can be concluded?
The twenty-first century arrival of Eastern Europeans in the UK is fundamentally different from previous waves of immigration to the UK. Most Jewish, Afro-Caribbean and South Asian people arriving here saw themselves as moving to Britain permanently. They concentrated their settlement in urban areas, creating mutually supportive communities where they could live, work, trade and worship together. Although they were, and sometimes still are, marginalised and victimised through racism and restricted social and economic mobility, their visibility, clustering and distinctiveness from indigenous White Britons conditioned how they interacted with wider society, the extent of their integration and the benefits and harms of UK residence.

By contrast, Eastern European migrants to the UK are;

• widely dispersed, many in rural areas. They may lack the sense of community and have limited opportunities to support one another.

• less visibly different to White British people. This mitigates the risk of active racist discrimination, but does not abolish it. Many people from Eastern Europe face substantial discrimination in the UK.
mostly younger adults, rather than larger family groups. They may lack accessible support from wider families.

likely to return temporarily or permanently to Eastern Europe. This provides them with recourse to resources in their country of origin, which is a safety valve but also sometimes a deterrent to deeper engagement here.

less united by a common faith, a source of cohesion and strength to minority communities.

arriving in a more multicultural and less discriminatory country, although one in which immigration, especially from Eastern Europe, is politically controversial.

Some of these factors reduce the risks that Eastern European migrants face, others exacerbate them. However, these migrants are far from uniformly vulnerable. Many come to the UK out of a desire to better themselves economically and aim to work hard before either returning to their country of origin or settling in the UK. They will tend therefore to be energetic and entrepreneurial.

We identified a number of specific issues for Eastern Europeans in Suffolk which give rise to important health needs or limit services’ ability to respond effectively:

**Adverse health factors**

Migrants bring with them lifestyles and behaviours from their country of origin. In the case of Eastern Europe, these include patterns of tobacco and alcohol consumption that pose a threat to health. These interact with the risks created by their migrant status, which include adverse mental health, a risk of sexually transmitted infections and occupational health threats from unsafe or unsatisfactory places of work.

**Dispersal**

In Suffolk, as in Norfolk and Lincolnshire, many Eastern Europeans work in the production and processing of food. Their workplaces are often rural and remote, ill-served by public transport and isolated from other resources and facilities; they may be unpleasant with inadequately mitigated hazards. The migrants may live in accommodation tied to their employment.

These factors are likely to place migrants at higher risk of physical and mental health problems. They will also make it harder for migrants to access health care and other resources to help them deal with these problems.
Lack of knowledge and understanding of UK resources

Eastern Europeans arrive from countries with a distinct culture, attitudes to and expectations of health and health care, and with healthcare and allied systems which reflect those factors. They understandably lack awareness of the systems in the UK, and may not accept readily the basis on which those systems are built, such as the centrality of primary care, the concept of screening and different approaches to prescribing.

As a result, Eastern European migrants may not be able to make good use of the NHS and other public services. Changes in entitlements add to the uncertainty about what is available. The inverse care law is at work here, with the most marginalised and disadvantaged migrants least able to make good use of the NHS.

Language

Problems with access to services are exacerbated by language difficulties. We found no data on the language proficiency of Eastern Europeans in Suffolk, but many arrive with only limited English. Language skills improve with time, but remain a constraint on migrants’ ability to engage, integrate and make use of local resources and facilities.

Limited data

From the review of routine datasets, it was apparent that none comprehensively captures the extent of the migrant population or their main health issues. Ethnicity is often used as a proxy for analysing migrant data, as migrant status is rarely recorded unless the service is specifically for migrants. Most computer systems only collect ethnicity, not capturing whether a patient is of Eastern European origin. Improving monitoring would allow increased understanding of the population using their services, where they are not meeting the needs of specific groups and where they need to target.
References


Appendix A: Countries defined as Eastern European by international Organisations

<table>
<thead>
<tr>
<th>United Nations Statistical Division</th>
<th>United Nations Regional Group Membership</th>
<th>Thesaurus of the European Union</th>
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<td>United Nations Regional Group Membership</td>
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