

Moreh, Chris ORCID:

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EU migrants' attitudes to UK healthcare

Concerns about EU migrants' use of public healthcare services in the UK are widespread. The assumption is that high quality free universal healthcare provision in the UK attracts migrants and allows potential abuse of the system. This research examines migrants' perceptions and preferences around healthcare, and our findings suggest that these assumptions are often unfounded, with migrants' preferring to have medical treatment in their country of origin, where they often perceive the standard of healthcare to be higher than that of the UK.

Key Points

- Nearly half of the migrants questioned in the study would prefer to have medical treatment in their country of origin with only 36% opting to have treatment in the UK.
- The majority of respondents thought that the quality of healthcare in their country of origin was of a higher standard than that of the UK.
- Migrants who are more integrated into British society are significantly more likely to prefer medical treatment in the UK, but not necessarily because of perceived higher quality standards.
- Low cost and convenience of medical treatment in the UK were popular reasons for migrants preferring treatment in the UK.

Introduction

Concerns about EU migrants' use of public healthcare services in the UK are widespread. These concerns are usually based on the assumption that healthcare provision is better in the UK compared to that in the EU migrants' countries of origin. Coupled with the fact that there is free universal access to healthcare for UK residents, it is often assumed that migrants seek treatment in the UK and potentially abuse the system.

Our research aimed to find out:

- (1) Where EU migrants prefer to have medical treatment – in the UK or in their countries of origin – and why?
- (2) If the quality of the healthcare in the country of origin influences the decision?
- (3) What other factors affect healthcare preferences?

Data

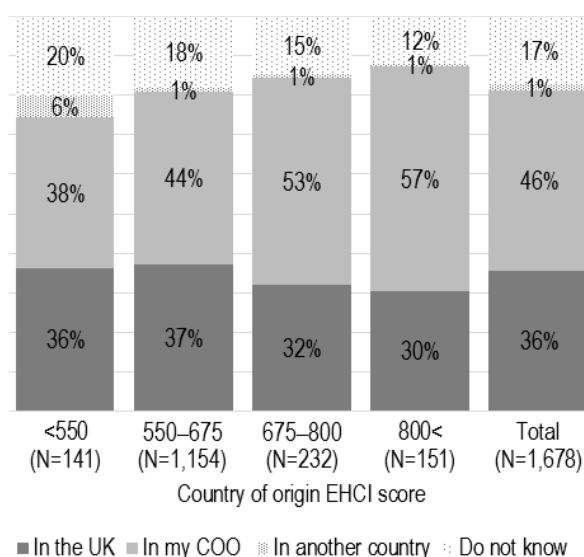


Figure 1: Treatment country preference by COO EHCI score

We conducted an online survey of migrants in the UK in March–June 2016. The analysis in this paper focuses particularly on one survey question: If you ever needed medical treatment, where would you rather have it? The question had four answer options: ‘In the UK’; ‘In my country of origin/citizenship’; ‘In another country’; and ‘Do not know’. Respondents were also able to provide written explanations for their choice. A total of 1,687 respondents answered the question, and 522 respondents provided additional qualitative explanations.

To measure differences in the quality of healthcare between different countries of origin we used the Euro Health Consumer Index 2016 (EHCI). The index assesses the ‘consumer friendliness’ of different healthcare systems, and while it does not provide a reliable measure of the actual quality of different systems, it is a useful tool for our classificatory purposes. We used the EHCI scores to classify the countries of origin of our respondents into four categories: with low (<550), medium-low (550–675), average (675–800) and high (800<) EHCI scores. The UK achieved 761 points on the EHCI scale, making it comparable to those in our average category.

Findings

Almost half (46%) of our respondents stated that, should they require medical treatment, they would prefer to have it in their country of origin, while only 36% would opt to have it in the UK (Figure 1). Very few (1%) would prefer a third country, while 17% did not have a clear preference. The preferences for treatment in the country of origin increases as EHCI score increases, with those from countries with healthcare systems that are the least consumer friendly being the least likely to prefer treatment in their country of origin. Certainty about where treatment would be sought was also higher in those from countries of origin with higher EHCI scores.

Using the further explanations given by respondents we identified six main reasons for their choice (Table 1).

Themes	In COO		In UK		Total	
	N	%	N	%	N	%
Better care	201	50	76	35	277	45
Better service	37	9	13	6	50	8
Better doctors	75	19	8	4	83	14
Convenience	58	15	97	45	155	25
Cost	13	3	15	7	28	5
Other	15	4	7	3	22	4
Total	399	100	215	100	615	100

Table 1: Reasons for treatment country preference (overview themes)

Quality (consisting of ‘better care’, ‘better service’ and ‘better doctors’) was the most important issue to our respondents. Interestingly, in contradiction to public opinion, perceived overall quality differences were more important among those who would opt for treatment in their country of origin (78%) than among those who prefer the UK (45%). On the other hand, convenience and lower cost were a stronger determinant for those preferring treatment in the UK.

Migrants coming from a country with low consumer friendliness (EHCI score <550) are half as likely to prefer medical treatment in their country of origin instead of the UK, compared to those from high EHCI (800<) countries (Figure 2). Those from countries with a medium-low to average EHCI classification did not significantly differ in their choice of treatment country from those coming from countries with high EHCI level (left panel of Figure 2). Among those for whom the quality of healthcare is of prime importance,

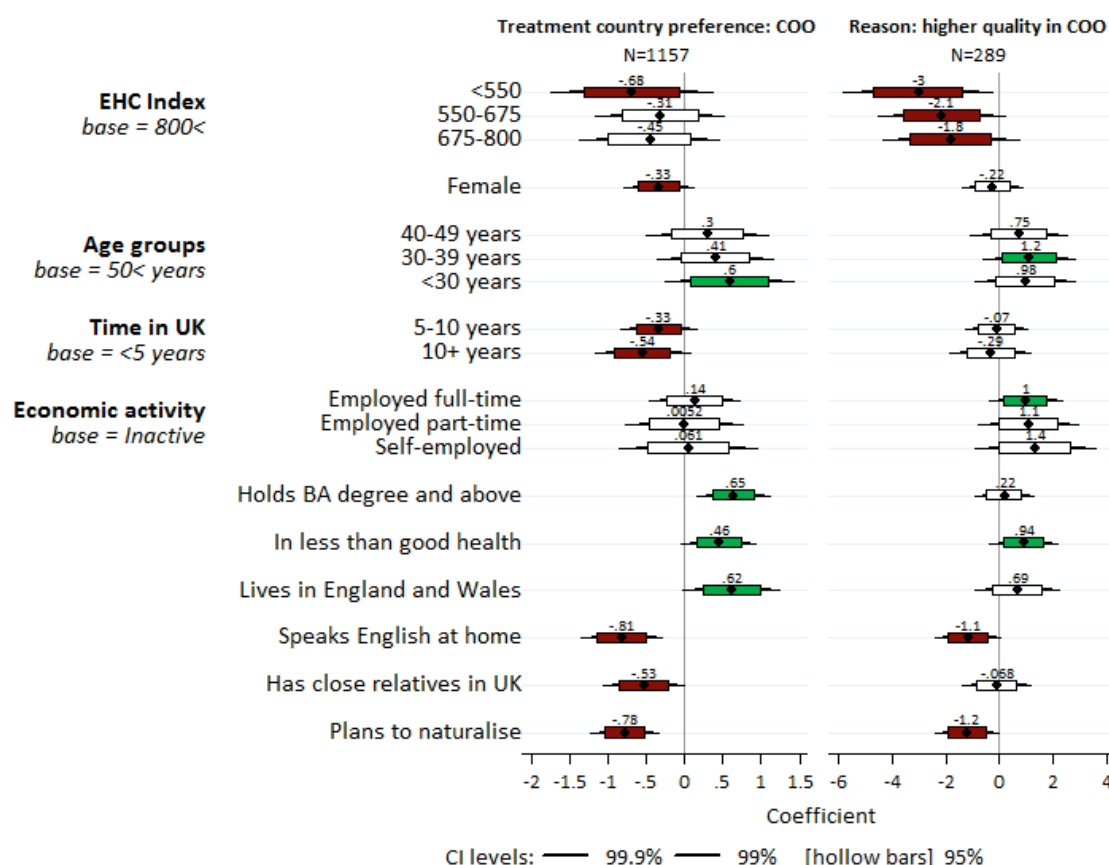
actual comparative differences in the standards of healthcare systems play a significant role, with those from a high-EHCI country being 20 times as likely to assess their country of origin as having higher healthcare standards as those from a low-EHCI country. However, when other reasons are also considered, the comparative quality of healthcare may only be a significant reason in the choice of where to access healthcare for those from countries with low as opposed to high EHCI ratings.

Conclusion

When looking at other factors that might influence healthcare preferences, we can draw two important conclusions. First, those in 'less than good health' (compared to those in 'good health'), and who therefore are more likely to have had actual

contact with different healthcare providers and to have made real choices about medical treatment options, are significantly more likely to prefer their country of origin both in overall terms and due to perceived higher quality of healthcare. Second, factors which can be construed as denoting a level of integration into British society (length of time spent in the UK, speaking English at home, having close relatives in the UK, or planning to naturalise as a British citizen) are associated with a higher likelihood to prefer medical treatment in the UK overall, although not necessarily because of perceived higher quality standards compared to the country of origin. Speaking English at home and planning to apply for British citizenship, nevertheless, are also statistically significant determinants of perceiving the quality of healthcare in the UK as higher.

Figure 2: Factors influencing preferences for the location of medical treatment and perceptions of quality standards (Results from two logistic regression models)



Notes: The base level of the dependent variable is "Prefers treatment in the UK". The base levels for the binary independent variables are: "Male", "No higher education", "In good health", "Lives in Scotland & Northern Ireland", "Does not speak English at home", "Does not have close relatives in the UK" and "Is not planning to naturalise".

The effect of a variable level is statistically significant at $p < .05$ where the bars are coloured. Red bars show a decrease in likelihood, while green bars show an increase. To calculate the approximate Odds Ratios (OR), raise 2.7183 to the power of the coefficients shown on the chart (e.g. $2.7183^{-0.68} = 0.507$). To express OR as a percentage, multiply OR-1 by 100 (e.g. $(0.507-1) \times 100 = -49.3\%$; i.e. "Those coming from a country with a low EHCI score (<550) are 49% less likely to prefer medical treatment in their COO instead of the UK, compared to those from high EHCI (800<) country").

Policy implications

Although the UK's 'free at the point of use' healthcare service is a core element of the British welfare state and of national pride, these results show that it often fails to convince those who have experienced other European healthcare systems of its true value. In fact, perceptions that the quality of healthcare in the UK is worse than that available in their countries of origin were the main factor in pushing EU migrants away from healthcare treatment in the UK. By contrast, convenience was the main reason for them to prefer treatment in the UK.

More importantly, our statistical results also show that those in poor health, and thus with real healthcare needs and actual contact with healthcare services, are even more likely to seek treatment elsewhere for reasons of better quality care.

However, 'integration' appears to shift these attitudes and practices. This also means that contrary to political rhetoric emphasising the migratory pull effects of free healthcare in the UK,

it is in fact those with higher levels of temporal (time spent in UK), cultural (e.g. speaking English at home) and civic integration (e.g. planning to naturalise) who would take advantage of healthcare provision.

With this in mind, healthcare policy and integration policy could be viewed and implemented in synergy. This would mean that improving early experiences and impressions of UK healthcare practice could potentially become an avenue for social integration. At the moment, based on our findings, negative experiences in the early years of migration may actually have an adverse effect.

The data analysed in this paper have emerged tangentially from a broader survey examining EU migrants' actions and plans for a post-Brexit future. The research team is now designing several follow-up quantitative and qualitative studies focused specifically on the question of healthcare practices after the UK's departure from the EU. These will provide a more in-depth and reliable contextual understanding for the findings discussed here.

Authors

Chris Moreh
(York St John University, CPC)

Derek McGhee
(Keele University, Institute for Social Inclusion)

Athina Vlachantoni
(University of Southampton, CPC)

Edited by Teresa McGowan
(University of Southampton, CPC)

www.cpc.ac.uk

ESRC Centre for Population Change

Building 58
Faculty of Social, Human and Mathematical
Sciences
University of Southampton
SO17 1BJ

Tel: +44(0)2380592579
Email: cpc@southampton.ac.uk



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