An independent, non-political monitoring organisation providing impartial, factual information on migration into the UK

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Health Consequences of Current Immigration Policy

Summary

1 The Government has commissioned an urgent review of the issues surrounding immigration and health screening. This paper underlines the likely scale of certain infectious diseases resulting from the flow of migrants into the UK, some of them from countries of high prevalence. The number of cases could run into tens of thousands and the potential cost to the NHS could over £1 billion per year. A fraction of this amount spent in the countries of origin would benefit a far greater number of sufferers. The case for prior health tests, as required by many other countries, is therefore very strong. Where prior testing is not possible, as for example with asylum seekers, compulsory tests on arrival would reduce the risks to others.

Detail

2 The lack of medical testing before entry of the substantial number of students and work permit holders and the absence of compulsory tests for asylum seekers on arrival means that a very considerable burden of chronic infective and related conditions is being added to the country's ills each year. The infections of particular concern are AIDS, the hepatitis viruses B and C and tuberculosis. In some of the countries from which immigrants are coming these conditions are present in much higher frequency than in the UK. Increasing numbers of persons with these infections in the UK represent a substantial additional burden on the Health Service.

3 Common to all these conditions is the high cost of treatment once the disease becomes manifest. For AIDS patients, it has been estimated that modern anti-viral therapy costs about £15,000 a year. For hepatitis B and C the cost of annual therapy is £10-12,000. Both these infections can lead to progressive disease with repeated hospital admissions and prolonged outpatient surveillance with even higher costs for those that come finally to liver transplantation. There are also calls on primary care.

4 This additional burden of disease has to be seen in the context of an NHS already struggling to cope with the increasing demands of modern medicine and with chronic shortages of doctors and nurses that are only likely to get worse and which will only be partially met by the current efforts to recruit abroad. The Commons Select Committee on Health reported on 10 June 2003 that they were appalled by the crisis in sexual health. The diseases mentioned above represent specific, previously uncommon, disorders quite apart from the burden of extra population on the NHS.

5 The clinical course of AIDS and the other diseases mentioned above are characterised by prolonged periods when the patients have no symptoms, and indeed may be unaware of the infection. This is of very great importance in public health because of their highly infectious nature and the risk of transmitting these infections to persons with whom they come into contact. The pool of infection already present in this country for these diseases was until recently relatively small. That there will be a progressively increasing load of illness from these infections over the years to come cannot be doubted.

Importance of pre-entry health tests

6 Only by routine health testing (most importantly blood tests and chest X-ray) prior to entry can these infections be detected. Some cases may already be in the disease stage but their symptoms, if histories were elicited, could be denied. Other cases are still in the stage of 'healthy carriage' and may remain like this for months or years before diseases appear. Their diagnosis in the absence of pre-entry testing will be dependent on whether blood checks are taken at any time, possibly for unrelated symptoms, or whether for any reason hospital investigations are required, but until then they will remain as an undiagnosed health hazard to the rest of the population.

7 The necessity for implementing such pre-entry health tests is urgent. Indeed, there are few countries in the world where they are not already in place. Most countries will not accept an individual found to have a positive AIDS test because of the risks to others and the costs that this would entail. The same may apply to the other conditions specified above. For instance, in the Emirates (Middle East), if a person is applying for a work permit and found to be hepatitis B positive, they may be allowed entry if they are healthy on clinical examination but would have to give an undertaking in writing that any healthcare costs for the hepatitis B infection would be borne by them.

Estimated numbers of infected immigrants and asylum seekers entering the UK

8 The likely number of patients entering the UK who are positive for these infections can be calculated from the known prevalence figures for the countries concerned and the number entering. Statistics, emanating, we understand, from the Public Health Laboratory Service, show that with an entry of 90,000 legal immigrants per annum coming from countries with a high hepatitis B prevalence, 6,300 new chronic hepatitis B infections in this country can be expected each year. Our own calculations suggest that the number could be substantially higher. We have compared the immigration figures for 2002 with the WHO table of prevalence for these diseases. The number of arrivals was 339,000 students, 135,000 work permit holders and 86,000 asylum seekers (excluding dependants). Multiplying by the prevalence in each country of origin gave an order of magnitude of 25,000 Hepatitis B cases – although accurate numbers are, of course, impossible in the absence of testing. About 5,500 of these are attributable to China and South Korea.

9 Hepatitis B has always been considered to be an infection with a very low prevalence in this country, which is the reason why vaccination of babies at birth and children is not carried out routinely. This policy will have to change, given the likelihood of transmission from the increasing number of positive subjects in the

community. Meanwhile, all applicants for British medical schools are being screened for Hepatitis B; if positive, they are refused admission so that future patients will not be put at risk.

10 As to hepatitis C, many of the countries with a high hepatitis B prevalence also have high prevalence for hepatitis C. The same calculation gives about 10,000 cases, mainly students, entering in 2002.

11 The Chief Medical Officer is already concerned about the rising mortality from liver disease in this country and the new hepatitis B and C positive entrants, and the infections that are spread from them, will constitute a further load.

12 With respect to AIDS, the incidence of this is increasing rapidly in many countries from which immigrants are coming, and indeed from where we are recruiting staff, including the Indian subcontinent and Asia. In certain states of Africa up to 25% of the population continue to be infected. Our calculation suggests very approximately 8,500 cases a year. However, this total is very sensitive to assumptions made about those coming from South Africa and Zimbabwe. We have assumed that those who come to Britain from South Africa have a very low incidence of HIV. If, in fact, the incidence is closer to the national average (20%) the number of cases will be far higher.

13 The results are set out in the following table. The calculation excludes dependants so will err on the low side.

		HIV	Hep B	Hep C
Annex A	Work Permit Holders	2,298	4,478	1,577
Annex B	Asylum seekers	3,656	5,498	1,430
	Sub total	5,954	9,976	3,007
Annex C	Students	2,518	15,394	7,989
	Total	8,472	25,370	10,996

14 For comparison, the number of HIV cases in the UK at the end of 2001 was, according to the Department of Health (DOH), 41,200 adults. Also according to the DOH, 70% of women giving birth with HIV were in London and 77% were born in Sub-Saharan Africa. This tends to confirm that the major HIV risks to public health in Britain originate in Sub-Saharan Africa.

15 There is also the important consideration that health care workers being recruited from abroad should be tested for AIDS and these other infections and only allowed to work in the health service when they are proven to be negative. The numbers are now considerable. For example, according to recent information from the Nursing and Midwifery Council, 1,833 Indian trainee nurses and midwives have been registered to work in Britain during the past year. According to the Society Guardian web site – quoting research carried out by the Royal College of Nursing, there are over 42,000

foreign nurses working in the UK, more than double the number of three years ago and equivalent to 12% of all registered nurses in England; in London, a quarter of all nurses are from overseas.

16 Finally, with respect to tuberculosis, WHO statistics show that the number of new incidences fell from 10,500 in 1980 to about 6,000 since 1987. However, it is now a matter of concern in a number of urban areas where immigrants have settled. Transmission to the local population is now well documented and in certain areas this is becoming a major health problem. The total number of cases has not, so far, greatly increased but the decline among the general population has been negated by an increase in particular areas. As a result it will be necessary to re-introduce Mantoux testing of the population along with BCG vaccination. As with the hepatitis B vaccination this has substantial direct Health Service costs as well as organisational demands.

Costs

17 Only orders of magnitude are possible. Students, who account for a significant proportion of suspected infections, especially Hepatitis B and C, are likely to return home before exhibiting symptoms. The cost of treatment for them is therefore not included; the main concern in their case is the risk of transmission to the local population. However, work permit holders and asylum seekers are here for several years, if not indefinitely. If 10,000 eventually require treatment for Hepatitis B for, say, three years, the total cost would be £300 million. Similarly, 3,000 cases of Hepatitis C would cost £90 million. But the greatest costs arise from HIV which, once illness develops will cost £15,000 for perhaps ten years, depending on survival. This could amount to £150,000 per patient. With nearly 6,000 cases arriving every year the potential cost to the NHS could be £900m. A fraction of such sums spent in the country of origin would benefit a far larger number of patients.

18 Adding these sums together would suggest that each year's intake of asylum seekers and work permit holders could involve a potential cost to the NHS of £1290 million. Such calculations cannot be precise but they certainly indicate that the potential costs are huge. This suggests an urgent need to introduce testing, at the very least for those, including students, who come from areas of high risk for these diseases.

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ANNEX A

Work Permits										
	Notes	WP issued to Aug 01		HIV rate	Nos.	Full year (Note 2)	Hepatitis B*	No. Hep B	Hep C**	No. Hep C
ARGENTINA		536		0.70%	4	6	1.50%	8	1.00%	5
AUSTRALIA		5,463		0.10%	5	8	0.50%	27	1.00%	55
BANGLADESH		513		<0.1%	0	0	4.00%	21	1.00%	5
BULGARIA		785		<0.1%	0	0	5.00%	39	1.00%	8
CANADA		2,060		0.30%	6	9	0.50%	10	1.00%	21
CHINA PEOPLES REPUBLIC OF		2,924		0.10%	3	4	12.00%	351	4.00%	117
GHANA		596		3.00%	18	27	12.00%	72	4.00%	24
INDIA		20,672		0.80%	165	248	4.00%	827	1.00%	207
JAMAICA		662		1.20%	8	12	2.00%	13	1.00%	7
JAPAN		2,790		<0.1%	0	0	2.00%	56	4.00%	112
KENYA		632		15.00%	95	142	12.00%	76	1.00%	6
MALAYSIA		2,265		0.40%	9	14	5.00%	113	4.00%	91
MAURITIUS		502		0.10%	1	1	8.00%	40	1.00%	5
NEW ZEALAND		2,395		0.10%	2	4	0.80%	19	1.00%	24
NIGERIA		1,770		5.80%	103	154	12.00%	212	1.00%	18
PAKISTAN		2,061		0.10%	2	3	3.00%	62	1.00%	21
PHILIPPINES		8,066		<0.1%	0	0	10.00%	807	4.00%	323
POLAND		1,161		0.10%	1	2	2.00%	23	1.00%	12
RUSSIA		1,013		0.90%	9	14	4.00%	41	1.00%	10
SOUTH AFRICA	1	9,248		0.10%	9	14	8.00%	740	1.00%	92
THAILAND		556		1.80%	10	15	8.00%	44	4.00%	22
TURKEY		539		<0.1%	0	0	4.00%	22	1.00%	5
UNITED STATES OF AMERICA		9,282		0.60%	56	84	0.50%	46	1.00%	93
ZIMBABWE		2,474		33.70%	834	1251	10.00%	247	4.00%	99
Total		78,965			1340	2010		3916		1380
Others	3	11,313			192	288		561		198
Grand Total		90,278			1532	2298		4478		1577

Notes: 1. South African immigrants to the UK assumed to have an HIV rate of 0.1%

2. Full year figures calculated pro-rata 3. Figures for other countries calculated pro-rata to named countries.

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ANNEX B

Asylum seekers								
		Percentage HIV	No. HIV		Hep B	No.Hep B	Hep C	No. Hep C
Afghanistan	7380	0	0		4.00%	295	1.00%	74
Albania	1205	0	0		7.00%	84	1.00%	12
Algeria	1060	0.1	1		5.00%	53	1.00%	11
Angola	1440	5.5	79		10.00%	144	1.00%	14
China	3735	0.1	4		12.00%	448	4.00%	149
Congo	2315	4.9	113		12.00%	278	4.00%	93
Czech Republic	1425	0	0		1.00%	14	1.00%	14
Eritrea	1190	2.8	33		11.00%	131	1.00%	12
FRY	2270	0.2	5		4.00%	91	1.00%	23
India	1880	0.8	15		4.00%	75	1.00%	19
Iran	2685	0	0		5.00%	134	1.00%	27
Iraq	14940	0	0		5.00%	747	1.00%	149
Jamaica	1320	1.2	16		2.00%	26	1.00%	13
Nigeria	1125	5.8	65		12.00%	135	1.00%	11
Pakistan	2440	0.1	2		3.00%	73	1.00%	24
Poland	1085	0.1	1		2.00%	22	1.00%	11
Romania	1235	0	0		7.00%	86	4.00%	49
Russia/Former USSR	2425	0.9	22		4.00%	97	1.00%	24
Sierra Leone	1160	7	81		12.00%	139	4.00%	46
Somalia	6680	1	67		10.00%	668	1.00%	67
Sri Lanka	3180	0	0		1.00%	32	1.00%	32
Turkey	2890	0	0		4.00%	116	1.00%	29
Zimbabwe	7695	33.7	2593		10.00%	770	4.00%	308
						0		
Total of above	72760		3098			4659		1212
Other countries	13105		558			839		218
Total of above	85865		3656			5498		1430

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ANNEX C

Students

		HIV incidence	Cases		Hep B	No. Hep B	Hep C	No. Hep C
Argentina	3900	0.7%	27		1.50%	59	1.00%	39
Australia	1850	0.1%	2		0.50%	9	1.00%	19
Bangladesh	2770	0.0%	0		4.00%	111	1.00%	28
Brazil	10700	0.7%	75		2.00%	214	4.00%	428
Canada	5060	0.3%	15		0.50%	25	1.00%	51
Chile	1690	0.3%	5		0.50%	8	1.00%	17
China	27000	0.1%	27		12.00%	3240	4.00%	1080
Colombia	2970	0.4%	12		1.30%	39	1.00%	30
Egypt	1210	0.0%	0		4.00%	48	10.00%	121
Ghana	2460	3.0%	74		12.00%	295	4.00%	98
Hong Kong	8030	0.1%	8		12.00%	964	4.00%	321
India	8260	0.8%	66		4.00%	330	1.00%	83
Indonesia	1000	0.1%	1		10.00%	100	1.00%	10
Israel	1830	0.1%	2		2.00%	37	1.00%	18
Japan	35000	0.0%	0		2.00%	700	4.00%	1400
Kenya	1920	15.0%	288		12.00%	230	1.00%	19
Libya	2670	0.1%	3		5.00%	134	4.00%	107
Malaysia	7600	0.4%	30		5.00%	380	4.00%	304
Mexico	4100	0.3%	12		1.00%	41	1.00%	41
Nigeria	3220	5.8%	187		12.00%	386	1.00%	32
Pakistan	4860	0.1%	5		3.00%	146	1.00%	49
Poland	14300	0.1%	14		2.00%	286	1.00%	143
Russia	12600	0.9%	113		4.00%	504	1.00%	126
Saudi Arabia	2280	0.0%	0		8.00%	182	1.00%	23
Singapore	2010	0.2%	4		12.00%	241	1.00%	20

South Africa**	1300	0.1%	1		8.00%	104	1.00%	13
South Korea	12900	0.0%	0		12.00%	1548	4.00%	516
Sri Lanka	1970	0.0%	0		1.00%	20	1.00%	20
Students (cont.)								
		HIV incidence	Cases		Hep B	No. Hep B	Hep C	No. Hep C
Taiwan	6890	0.0%	0		12.00%	827	4.00%	276
Thailand	3470	1.8%	62		8.00%	278	4.00%	139
Turkey	5960	0.0%	0		4.00%	238	1.00%	60
USA	64500	0.6%	387		0.50%	323	1.00%	645
Venezuela	2330	0.5%	12		2.00%	47	1.00%	23
Zimbabwe	1700	33.7%	573		10.00%	170	4.00%	68
Total of above	270310		2006			12263		6365
Other countries (pro-rata)	69000		512			3130		1625
Grand Total	339310		2518			15394		7989
*Unlikely to have access to retroviral drugs in home country?								
** South Africa HIV incidence assumed to be 0.1% for people entering the UK								