COVID-19
Impact Assessment Framework

Risks and responses for people in the UK immigration system

May 2020

Migration Exchange
at Global Dialogue

COVID-19 Impact Assessment Framework: Risks and responses for people in the UK immigration system

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It was conducted by a research team from the Institute for Public Policy Research (IPPR), Migration Observatory and a group of independent public health experts.
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About Migration Exchange

Migration Exchange is an informal network of independent funders, established in 2010. We aim to improve the lives of people who migrate, and receiving communities in the UK, by informing public debate on migration and supporting welcoming communities. We do this through commissioning research to inform funders and key partners to act on shared concerns; supporting coordination and building capacity in the sector, and aligning grants to enable activity to take place at scale or increase the potential for success. The network is independent and non-partisan.

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Executive Summary

The COVID-19 pandemic has major implications for people within the immigration system. The conditions attached to people's immigration status – their rights to live and work in the UK, to access healthcare and other public services, and to make use of public funds – shape their experience of the pandemic. It is therefore critical for the UK to develop an equitable response that includes all people, regardless of immigration status, into the foreground of policy discourse.

To ensure the UK's response is effective, this report assesses the specific risks associated with COVID-19 for people within the UK's immigration system. We explore four types of risks:

- of contracting COVID-19
- of having worse clinical outcomes following COVID-19 infection
- of facing indirect health impacts due to the pandemic
- of facing more severe socioeconomic consequences as a result of the pandemic.

For each, we identify a number of relevant factors that could exacerbate these risks. There are also demographic factors – such as gender and ethnicity – that influence an individual's experience of COVID-19 and have implications for a number of these risks, with the disproportionate impact on Black and Minority Ethnic communities intersecting with the experience of many within the immigration system.

The analysis involves first identifying the potential risk factors within each category and then using these to assess the risks for sixteen different cohorts within the immigration system. We also include a more in-depth analysis of the socio-economic and health impacts through new analysis of UK household survey data. Finally, we develop a series of policy considerations for charities, service providers and policymakers.

Cohort analysis

We summarise below some of the critical risks associated with the COVID-19 pandemic for specific immigration cohorts that we have identified.

Cohorts at particular risk of contracting COVID-19

- People seeking asylum are more likely to live in poorly maintained and overcrowded accommodation, particularly those living in initial and dispersal accommodation and in hotels. This limits their ability to socially distance and could put them at greater risk of contracting the virus.
- Detention centres pose a particular risk for elevated transmission, due to shared cells and communal areas, poor hygiene and sanitation measures, and insufficient procedures for self-isolation.
- Some cohorts of people within the immigration system are concentrated in 'key worker' roles – for instance, Tier 2 (General) workers are more likely to be doctors or nurses, while EU citizens are more likely to be working in food manufacturing. This puts them at higher risk of coming into contact with, and thus contracting, COVID-19 infection. Those working in the

informal job market are less likely to receive adequate Personal Protective Equipment (PPE) from their employer, with issues accessing such protection across the NHS also well documented.

Cohorts at particular risk of worse clinical outcomes following COVID-19 infection

- People without immigration status face major barriers to accessing healthcare, many of which have been exacerbated during the COVID-19 pandemic. People who are undocumented are charged for NHS secondary care and can be deterred from accessing healthcare due to fears of unaffordable bills and immigration enforcement. While all individuals are entitled to primary care, free of charge, there are low levels of GP registration among people who are undocumented, with many reports of refusals by GP practices.
- People affected by trafficking or modern slavery are at particular risk of not receiving treatment for COVID-19. Survivors have reported that traffickers often restricted their access to health services. Many may not be officially identified as victims of trafficking and so could be ineligible for free secondary care.
- People from the Windrush generation, particularly those who have not yet had their status resolved, are at high risk of more serious illness from COVID-19 due to their age profile and potential denial of healthcare rights. Black Caribbean ethnicity has also been identified as a risk factor for worse disease outcomes.

Cohorts at particular risk of indirect health impacts resulting from the COVID-19 pandemic

- People seeking asylum are at higher risk of experiencing mental distress, with some studies indicating high levels of anxiety, depression and PTSD in this group, which could be exacerbated by increased security and restriction of movement during the COVID-19 pandemic.
- Domestic workers are particularly vulnerable to violence, abuse and exploitation, as they often live in the same household as their employers, with one survey of migrant domestic workers finding around 59 per cent of participants reported experiencing abuse at work.
- People who experience domestic violence are only eligible for support via the Destitution Domestic Violence (DDV) concession in limited circumstances. There is evidence that restrictions of movement in response to COVID-19 have led to a significant increase in domestic violence, but the restrictive nature of the DDV concession, and the exclusion of certain cohorts from the legislative response, could make it harder for people affected by domestic violence during the pandemic to seek support.

Cohorts at particular risk of socioeconomic impacts resulting from the COVID-19 pandemic

- People without immigration status could be further pushed into poverty as a result of the COVID-19 pandemic, as they are not eligible for public funds and have no legal permission to work. Moreover, many charities and community networks that normally provide food and support to this cohort and others in the immigration system have suspended or reduced their services.
- People on family visas (e.g. partner visas) are at high risk of suffering hardship as a result of the pandemic. Family visa holders have a No Recourse to Public Funds (NRPF) condition, so they are not entitled to housing assistance or benefits such as Universal Credit. In addition, many are also expected to meet the minimum income requirement and pay substantial visa

fees in order to extend their leave to remain. The current crisis therefore risks jeopardising their status in the UK.

- Many EU citizens who lose income as a result of the COVID-19 pandemic will face a minimal social safety net. Significant numbers of EU citizens struggling with living costs may not be eligible for housing assistance or benefits such as Universal Credit, because those who have not yet secured 'settled status' will need to prove an alternative 'right to reside' as part of the Habitual Residence Test for accessing such benefits and support.

Survey analysis

In addition to the cohort analysis, we also explore in further detail the labour market and health risks of COVID-19 for non-UK citizens using the Labour Force Survey and the Annual Population Survey. We are not able to break down our analysis by immigration status. Instead we use length of residence – i.e. whether someone has arrived in the UK in the last five years – on the assumption that most non-EU citizens who have arrived in the UK in the last five years will have a NRPF condition attached to their visa and most EU citizens who have arrived in the last five years will not yet have settled status. The main findings from our analysis include:

Labour market risks

- The current economic crisis has exacerbated the vulnerability of the population who were already in a precarious economic situation before the pandemic, such as workers in low-paid and insecure jobs. On average, EU citizens are a particularly vulnerable group: compared to non-EU and UK citizens, EU citizens who migrated to the UK during the last five years are overrepresented in low-paid occupations and among workers on zero-hour jobs or on non-permanent contracts.
- A quarter of recently migrated EU citizens also work in one of the most sectors most affected by the pandemic (e.g. hospitality or retail). This share is also high for non-EU citizens who moved to the UK more than five years ago (23 per cent).
- Among workers in the most affected sectors, those on non-permanent contracts or who are self-employed are especially at risk of experiencing large income losses: about 74,000 of non-EU citizens and 99,000 of EU citizens are likely to be in this situation.

Health risks

- On average, non-EU and EU citizens are less likely to have a limiting health condition than UK citizens. This is particularly the case among non-UK citizens who moved to the UK in the last five years. Non-UK citizens have also a lower prevalence of long-lasting mental health problems.
- The observed differences are partially related to the younger age profile of non-UK citizens, but in general non-UK citizens tend to be healthier than the local population. Nonetheless, given the high heterogeneity within the EU and, especially, the non-EU citizen population, health needs vary substantially and may be higher in certain groups, particularly those who are more marginalised or with insecure immigration status.

Policy considerations

Based on our critical appraisal of the existing evidence outlined in this report, we have identified a number of key policy considerations that are pertinent for policymakers, public services and non-governmental organisations:

Short-term

Our analysis demonstrates that several government policies undermine the national public health response and are particularly inappropriate to continue to enforce in the current context. These include: data sharing between public services and the Home Office, enforcing of current NHS charging regulations, policies that restrict access to benefits such as the NRPF condition and the Habitual Residence Test, and the detention of people for the purposes of immigration enforcement. An automatic extension for all visa holders should also be considered. Any policy charge needs to be accompanied with a robust and culturally appropriate communications campaign to inform people within the immigration system, as well as the public and service delivery staff concerned.

Medium-term

There is a need for targeted investment for mental health services, tailored to support people within the immigration system. It is also critical to monitor how the changing labour market affects people in the immigration system and to guard against the risk of a rise in exploitative working conditions in response to higher levels of unemployment. Finally, individuals in the immigration system could be forced into overstaying their current visa and/or losing their immigration status due to the COVID-19 pandemic, compounded by the inflexibility of current immigration rules. This should be monitored closely, and appropriate adjustments and concessions made to avoid unjust penalisation of people affected by immigration control.

Long-term

It is critical for the UK to implement a more inclusive and equitable approach to health policies and access to healthcare. Immigration and public service policies must recognise the interconnections between health, immigration status, and demographic factors such as gender and ethnicity. A new strategy is needed to address the structural barriers and policy failings that are having deleterious impacts on health across cohorts within the immigration system – in particular, the government's 'hostile environment' policies, which have restricted access to services and created a climate of fear for many communities.

1. Introduction

The COVID-19 pandemic has major implications for people within the UK's immigration system. People within the immigration system can face particular restrictions to living securely in the UK and to accessing necessary and life-saving NHS treatment, social welfare and housing support. This means that their experience of the COVID-19 pandemic will differ from others in important ways.

This briefing develops a framework for understanding the risks associated with COVID-19 for different cohorts of people within the immigration system. By assessing the risks for sixteen different cohorts, we aim to provide an overview of how the immigration system relates to the impact of COVID-19 on individuals. The briefing is a collaborative effort, commissioned by Migration Exchange and bringing together public health expertise from Rachel Burns and Lisa Murphy, data gathering from the Migration Observatory at the University of Oxford, and policy analysis from the Institute for Public Policy Research.

The briefing is divided into five parts. The next part summarises the different risk factors associated with COVID-19 – exploring in particular the factors that increase the risk of contracting COVID-19, the risk of having worse clinical outcomes from COVID-19, as well as the risks of indirect health and socioeconomic impacts resulting from the pandemic. This is then followed by our cohort analysis, which examines the risk factors associated with COVID-19 across sixteen different cohorts. The following two sections then explore in greater detail the economic and health risks for non-UK citizens, drawing on data that cannot disaggregated by immigration cohort. Finally, we summarise the main policy considerations to draw from our analysis, with a focus on the implications for charities, service providers, and policymakers.

2. Summary of risk factors

This section summarises the risk factors associated with COVID-19. Alongside demographic factors, there are several factors we have identified, and are purported in relevant analyses and scientific literature, that impact an individual's risk of:

- contracting the COVID-19 virus;
- having a more serious illness or worse clinical outcomes following COVID-19 infection;
- experiencing greater indirect health impacts due to the COVID-19 pandemic;
- facing more severe socioeconomic consequences due to the COVID-19 pandemic.

Many of these factors, other than demographic characteristics, are determined by the immigration cohort to which an individual belongs – with some individuals and households having experience of being part of more than one of these groups. In particular, a lack of access to public services and financial support – both before and during the COVID-19 pandemic – introduces a wide range of risks for many people within the immigration system. It is important to remember that many people will experience a number of these risk factors simultaneously, and that they will interplay with, and at times exacerbate, one another.

We have tried to account for new changes and emergency measures introduced during the pandemic so far, but this is an evolving area and thus there may be further developments which impact an individual's risk factors following publication.

Demographic characteristics associated with COVID-19 risks

Age	Age has an impact on susceptibility to COVID-19 and disease course, with older patients seen to have an increased risk of severe disease and mortality. Age can also impact an individual's health-seeking behaviour.
Sex	Sex has an impact on an individual's experience of COVID-19 infection, as well as of wider societal and policy implications of the pandemic. There is evidence to suggest that men experience more severe clinical outcomes from COVID-19.
Ethnicity and racial identity	Ethnicity and racial identities can relate to the risks of developing some of the health conditions seen to increase the severity of COVID-19, although the evidence suggests that the relationship is complex and needs to begin with an examination of how structural inequalities influence these health outcomes more broadly. Leaders of racial justice organisations, such as the Runnymede Trust and the Race Equality Foundation, have highlighted that BAME groups are disproportionately represented in lower socioeconomic deciles – with specific health needs and political factors further compounding the impact of the COVID-19 pandemic.[12] Racial identity intersects with socioeconomic inequalities in a number of ways, as well as with experience of and access to healthcare – all of which can influence an individual's experience of COVID-19. In addition, for people within the immigration system, their experience of discrimination, barriers to public services and socio-economic status closely intersect with the UK's BAME population.
Disability	Disability may impact an individual's risk of contracting COVID-19 due to sustained contact with carers, as well as the severity of disease course and the ability to access healthcare and other forms of support within the context of social distancing.

Factors that increase an individual's risk of contracting COVID-19

Language capability	People who are unable to speak or understand English or access health information in their own language are at risk of not understanding, or receiving, public health messaging or healthcare advice related to COVID-19. The availability of key guidance from Public Health England in languages other than English has been variable and at times delayed, with translation and facilitation of culturally and linguistically appropriate messaging falling to non-governmental organisations, such as Doctors of the World.[3] Moreover, long-term resources for English language support classes have been cut significantly over the past decade, including a reduction of more than 60 per cent in funding, limiting access for people who speak other languages.[4]
Health literacy	People who struggle to access, understand, appraise and apply health information or who face barriers in navigating the complexity of the NHS

	may not be able to adhere to public health messaging or healthcare advice related to COVID-19.
Accommodation type (including those who are roofless, houseless, in inadequate or insecure housing, and housed or confined in an institutional facility)	A lack of access to housing that is suitable and secure has a range of impacts on individual health and experience of disease. People who are migrants are statistically more likely to live in overcrowded and multi-generational housing – presenting a challenge to maintaining adequate sanitation, as well as making it difficult, or impossible, for unwell, vulnerable or older members to isolate themselves.[5] There is evidence that several government policies are impacting the ability of people in the immigration system to access secure housing. For example, the 'right to rent' scheme, introduced in England in 2016, requires landlords to check the immigration status of tenants – with strong evidence of landlords discriminating against potential tenants based on their nationality, ethnicity and visa status.[6] Poorly maintained housing, especially if affected by damp or mould, can increase the risk of worse respiratory health and thus worse clinical outcomes if COVID-19 is contracted. Individuals classed as homeless will face even greater challenges in adhering to public health advice. Although measures have been taken to provide shelter for these individuals, concerns have been raised that some people within the immigration system may be unwilling or unable to utilise this support, due to fear of immigration enforcement. There is concern that COVID-19 outbreaks could occur in immigration detention centres, Initial Accommodation Centres or other housing provided to those seeking asylum, where individuals may not be able to isolate or may be further deprived of liberties in order to be isolated from others.
Number of people in household	With more people in a household, each individual has a greater within-household contact rate and the household as a whole has a greater between-household contact rate. For example, more people within the house could become infected as there are more people; more people could be working/travelling/shopping and as a result increase the number of contact points between different households. Overcrowded housing is a known driver of increased infectious disease transmission, including of COVID-19, due to increased difficulty in ensuring physical distancing, maintaining high levels of sanitation and isolating unwell household members.
Number of generations living in household	Where multiple generations live in one household, elderly and vulnerable individuals may struggle, or be unable, to physically distance themselves in a safe manner. For example, older people in multigenerational households could have increased risk of exposure if younger people are not able to properly social distance. However, if no one is working and there is effective social distancing, older people might have more support for essential activities such as food shopping and less risk of social isolation.
Agency of members of household	Gender can have a role in the power dynamics within the household and this can impact susceptibility to COVID-19. For example, gender roles can impact health-seeking behaviour, caring responsibilities within the

	household, and risk of exposure to COVID-19 due to ability to socially distance during work or travel.
Occupational exposure	People who are still working and leaving the household during this period have an increased risk of exposure to COVID-19. Moreover, fixed work timetables might make workers shop for food or travel during busier periods. Those working as 'key workers' or in places with minimal personal protective equipment (PPE) available are at even more risk. People who are migrants are more likely to be working in certain key worker roles, making up approximately one fifth of the health and social care workforce and more than 40 per cent of food production workers.[7] Those working in the informal job market are less likely to receive adequate PPE from employers.
Travel	Utilising public transport such as buses or trains, rather than a private car or similar, can put an individual at increased risk of being exposed to, and thus contracting, COVID-19.
Geographic location	There may be discrepancies in services provided by councils and businesses in areas of lower socioeconomic status (e.g. reduced public health messaging and signage; less sanitising and cleaning of public housing and estates; more limited food and accommodation distribution to those in need).

Factors that increase risk of worse clinical health outcomes from COVID-19

Underlying health conditions	A number of health conditions have been linked to increased morbidity and mortality of COVID-19. Although the evidence behind each of these is evolving, they include respiratory conditions, cardiovascular disease, and immunosuppressive conditions and treatments. Other determinants of health, such as obesity and smoking status, have also been implicated in a poorer prognosis after contracting COVID-19.
Eligibility to access NHS care	The ability to access healthcare has knock-on consequences for individuals' health outcomes following COVID-19 infection, with concern that those unable to access or afford NHS care will suffer increased rates of death (see Box 2.1). Limited healthcare entitlement has left some people with untreated conditions and poorly managed chronic conditions which, should they contract COVID-19, may impact on their outcomes.
Deterrence from healthcare	The 'hostile environment', a suite of national policies intended to make living in the UK untenable for individuals without immigration status, functions by both embedding immigration enforcement within, and restricting access to, public services. These policy interventions have generated a culture within public services that prioritises entitlement rules

	over service provision. Active measures of deterrence have led to a distrust, and even fear, of public services amongst people within the immigration system. There are reports of racial discrimination, as well as of data of patients and victims of crime being shared with the Home Office, thus deterring people from accessing support.[8] The increase in surveillance and national security during the COVID-19 pandemic, such as the increased police presence and powers, could exacerbate this sentiment and result in further exclusion of people within the immigration system. Deterrence from healthcare among people within the immigration system, regardless of formal eligibility, is well documented.[9] In 2017, a memorandum of understanding was reached between NHS Digital and the Home Office, resulting in the sharing of patient personal data with the Home Office for the purposes of immigration enforcement. Although now theoretically suspended, there is still sharing of personal information in the context of NHS 'eligibility checking' and of those with outstanding debts to the NHS. Its legacy of fear is still felt, further exacerbated by visible messaging around NHS charging within healthcare settings. Public Health England announced that treatment for COVID-19 infection is included in this list of exempt conditions, yet ensuring this message is disseminated widely enough is challenging.[10] Some people within the immigration system may, understandably, be concerned that should they test negative for COVID-19, or simultaneously be treated for other health conditions while under NHS care, that they will be facing large bills, leading to a delay in their presentation to healthcare services and potentially worse outcomes. Although eligibility for primary care is universal, barriers to registration with General Practices are well documented[11], with concern raised by charities, such as Doctors of the World, that this has been exacerbated by the COVID-19 pandemic.
Inclusive healthcare	When people within the immigration system are deterred from accessing health and social care, this also results in a lack of data being gathered on this group and their experience of COVID-19. There has been research and innovation centring on the use of technology to support COVID-19 treatment in healthcare facilities, including the use of artificial intelligence algorithms for predicting disease course and advising management. A lack of diverse training data due to the exclusion of specific cohorts from accessing healthcare will result in biased algorithms being developed and deployed, to the detriment of people within the immigration system.

Factors that increase risk of indirect health impacts

Existing or new health conditions	There is potential indirect impact of reduced healthcare provision during the pandemic for primary, secondary and emergency services. Previous history of mental ill health or experience of adverse psychological experiences could increase the likelihood of the COVID-19 pandemic negatively impacting an individual's mental health. The increase in surveillance and national security during the COVID-19 pandemic could exacerbate the hostility and exclusion felt by some people within the immigration system. This will be particularly strongly felt by individuals impacted by domestic violence or who have fled state violence, as they may find living under such constrictions detrimental impact to their mental well-being.
Domestic violence	There is already evidence from in the UK and internationally that restrictions on movement due to the COVID-19 pandemic have resulted in increased incidents of domestic violence. Domestic violence, be it physical, emotional, psychological, financial or sexual, can impact an individual's physical, mental and behavioural health. There is evidence that women with insecure immigration status or with No Recourse to Public Funds (NRPF) are at particular risk due to the barriers they experience to accessing support.[12]
Destitution	There is good evidence that precarity of income, poor housing and limited access to necessities (such as food) can have a negative impact on mental and physical health. Destitution could be created or exacerbated by the economic consequences of the COVID-19 pandemic, such as through loss of income or increases in the price of consumer goods. People with NRPF are not entitled to benefits such as Universal Credit and housing or homelessness support, rendering their situation even more precarious in a collapsing economy.
Exacerbation of societal exclusion	There have been increasing instances of COVID-19 related racism and xenophobia during recent months, with several reports of racially motivated attacks against people of Chinese ethnicity in particular.[13] This increased marginalisation of individuals within the immigration system during a time when many are dealing with financial precarity and/or being asked to risk their health to participate in the UK's pandemic response, serves only to deepen the exclusion this population feels. This can have a range of health impacts, as well as deterring people from accessing health and social care.

Factors that increase risk of socioeconomic impact

Financial precarity	Being in a financially precarious situation, such as being in low paid or insecure work, prior to the COVID-19 pandemic puts individuals at a higher risk of facing severe economic impacts due to business closures and the lockdown. This intersects with people's housing stability, their access to basic provisions such as medicine and food, and their ability to socially distance if needed.
Debt	Previous debt, such as NHS debt or debt resulting from immigration costs, can mean that some people in the immigration system are in financially precarious situations – and thus if they face any further loss of income during the COVID-19 pandemic they could become (further) destitute.
Access to financial and social support	Lack of eligibility for government financial support, such as access to Universal Credit or COVID-19 specific income support schemes, can create or exacerbate destitution faced by people within the immigration system (see Box 2.2). The third sector is an important source of support for people within the immigration system. Charities and community networks across the UK provide food, health and social care, and a sense of community. Additionally, these groups provide phone credit and data, an important source of information and social contact. The current suspension of many groups' face-to-face support and/or reduction in operational capacity could have major ramifications on people's health and wellbeing.
Immigration status	Someone's immigration status could add to their uncertainty for the length of the pandemic, due to pauses or delays in application processing. There is the risk that some people may become "overstayers" if unable to leave the UK or apply for further leave/alternative status during the COVID-19 pandemic. The immigration status of some people may change due to the impact of the COVID-19 pandemic, and thus their eligibility for healthcare and financial support may be impacted.
Dependents	Parents that are sole carers, or individuals sending remittances and/or with dependents abroad, will face additional financial pressures.

Box 2.1: Eligibility for NHS care

In England, secondary NHS care (i.e. treatment in hospital and community services) is only free for those who are 'ordinarily resident'. Ordinary residence is defined as normally residing in the country, lawfully and voluntarily, for a 'settled purpose' as part of the regular order of one's life for the time being. Non-EEA citizens must have indefinite leave to remain in order to be defined as ordinarily resident.

People who are not ordinarily resident in England are charged for their secondary healthcare at 150 per cent of the cost of treatment. Non-EEA citizens who apply for visas longer than six months are exempted from charges but must pay an immigration health surcharge as part of their visa application. This means that NHS charges are meant to be targeted at visitors and those on short-term visas, as well as people without immigration status. For non-urgent treatment, upfront payment is required.

Some specific groups – such as people with an existing asylum application – are exempted from charges, and some specific types of treatment – such as accident and emergency services – are also exempted. The government has exempted testing and treatment for COVID-19 from charging. However, individuals who are suspected to suffer from COVID-19 may still be charged for treatment for underlying conditions or for other treatment if they are tested and found not to have the virus, which could deter people subject to charging from seeking help.[14]

Moreover, NHS charging regulations are complex and difficult to implement, with misapplication of charging or urgency decisions disproportionately affecting the most marginalised populations. For instance, in the case of the Windrush generation, many were ordinarily resident in the UK but were denied or delayed healthcare based on inability to prove their entitlement. In addition, patient information is shared between NHS Digital and the Home Office to determine an individual's eligibility for free care. The ongoing data sharing plays a large part in deterring people from seeking healthcare.

Some specific groups – such as people with an existing asylum application – are exempted from charges, and some specific types of treatment – such as accident and emergency services – are also exempted. The government has exempted testing and treatment for COVID-19 from charging. However, individuals who are suspected to suffer from COVID-19 may still be charged for treatment for underlying conditions or for other treatment if they are tested and found not to have the virus, which could deter people subject to charging from seeking help.

Primary care is available to all free of charge, regardless of immigration status. There is, however, evidence of significant barriers faced by those in the immigration system to registering with primary care services – such as requests for paperwork and identification that are not consistent with NHS guidance.

The rules in Scotland, Wales and Northern Ireland are similar, though there are some important differences. Perhaps most notably, in Scotland, Wales and Northern Ireland asylum seekers who have their applications refused are exempted from healthcare charges, which is not the case in England.

Box 2.2: 'No Recourse to Public Funds' (NRPF) conditions

A number of immigration routes – particularly temporary visas for non-EU citizens – are attached to 'No Recourse to Public Funds' (NRPF) conditions. People with the NRPF condition are not eligible to access public funds. The definition of public funds is complex and includes most benefits (such as Universal Credit), as well as housing and homelessness support. Certain contributory benefits do not count as public funds. The government has also made clear that people with NRPF are eligible for the Job Retention Scheme.

There are some limited concessions for people with NRPF conditions, which have been slightly amended in light of the current crisis. People on the '10 year route' can apply to the Home Office to lift the NRPF condition, provided they can show that they are destitute, that there are compelling reasons relating to the welfare of a child due to their low income, or that there are exceptional financial circumstances. People on five-year parent/partner visas can also apply for the concession, but must switch onto the 10 year route to do so – which would significantly extend the period they need to wait in order to secure permanent residence.

Despite the NRPF condition, local authorities may nevertheless have a duty to provide accommodation and support to people with NRPF in certain circumstances. For instance, under Section 17 of the Children's Act local authorities have a duty to safeguard and promote the welfare of children in need in their area.[15]

After a recent legal challenge, the High Court has found that elements of the NRPF policy are unlawful; a detailed order setting out how the policy needs to be changed is expected shortly.[16]

3. Cohort analysis

Our cohort analysis summarises the main risk factors associated with COVID-19 for sixteen different cohorts of people within the immigration and asylum system. We have selected the below sixteen cohorts because we have found that they face specific risks due to the nature of their immigration status and the rights and restrictions attached to their status. We recognise that this is not a comprehensive list and that some cohorts are not mutually exclusive, but we have judged this is the most useful way of organising the impacts of different parts of the immigration system. Where we have not identified risks for specific cohorts, this is not because we believe there are no risks; it is because we have not found substantiated evidence of these risks, often because there is no available data broken down by specific immigration cohort.

Where appropriate, we have included references to some of the recent government interventions that have been introduced in response to the Coronavirus crisis (see Box 3.1 for its general policy on extensions of leave). Our analysis is generally at the UK level and most relevant policy is UK-wide. However, in some areas policy differs across the UK. Generally, for these areas we focus on the policy context in England; though, where feasible, we refer to differing policies in Scotland, Wales and Northern Ireland (e.g. in relation to healthcare charging).

Adults and families in the process of claiming asylum

Size: Total of 56,000 people who had applied for asylum and waiting for an outcome at end of 2019		
Risk Factors	Risk of contraction	Poor housing, overcrowding in initial accommodation, and asylum travel requirements
	Risk of worse clinical outcomes	People may arrive with poorly controlled chronic health conditions and may be deterred from accessing healthcare due to hostile environment
	Risk of indirect health impacts	Evidence of greater mental health needs – in particular, depression, anxiety and PTSD
	Risk of socioeconomic impacts	No permission to work for first 12 months and limited access to benefits

Overview

At the end of 2019, there were a total of around 56,000 people (including dependants) who had applied for asylum in the UK and were awaiting the outcome of their application.[17]

People in the process of making asylum applications have no permission to work in the UK (unless they have been waiting for more than 12 months and they can find work in jobs on the Shortage Occupation List). If they can prove they are destitute or likely to become destitute, they are entitled to Section 95 support.[i,18] This can include both accommodation and/or weekly payments of £37.75 paid through an ASPEN card.[19] Around 44,000 people in the UK were in receipt of Section 95 support at the end of 2019, with most of these in dispersal accommodation (see Table 3.1 below).

While waiting for their Section 95 decision, asylum seekers can claim Section 98 support if they appear destitute.[20] This entitles them to stay in Initial Accommodation – generally this means a temporary stay in hostels provided by the Home Office. Around 3,000 people were in receipt of Section 98 support at the end of 2019.

Section 95	43,549
Dispersed Accommodation	40,702
Subsistence Only	2,847
Section 4	3,804
Section 98	2,738
Grand Total	50,091

Table 3.1. Asylum seekers in receipt of support 31 Dec 2019

Source: Home Office Immigration Statistics, year ending December 2019, Asylum table Asy_D09

[i] Destitution is defined as not having adequate accommodation or any means of obtaining it, or having adequate accommodation but not being able to meet other essential needs.

Factors that increase risk of contracting COVID-19

People seeking asylum are more likely to live in poorly maintained and overcrowded housing, and there are more likely to be multiple generations living together under one roof.[21] In particular, initial accommodation centres (IACs) (which tend to be hostels) and dispersal accommodation (which tend to be HMOs) that are used to provide housing for those seeking asylum are often poorly designed for social physical distancing. There are concerns with sharing of bedrooms (and in some cases sharing of beds), communal washing and cooking spaces, and a lack of hygiene products.[22] Related concerns have also been raised about hotel accommodation for people seeking asylum. Given that transfers to dispersal accommodation are being delayed or stopped in response to COVID-19, there is also a risk of overcrowding as the number of people in IACs increases.

There are also risks for people travelling for the purposes of their asylum application. In order to seek asylum, individuals are still expected to physically attend an Asylum Intake Unit.[23] Furthermore, while reporting requirements for people seeking asylum have been temporarily suspended, this message has not always been clearly communicated to people with an asylum claim in process – who may be fearful of jeopardising their claim. This means that people may still attempt to travel to reporting centres, putting themselves at risk of coming into contact with COVID-19.

Factors that increase risk of worse clinical outcomes from COVID-19

There is limited evidence on the prevalence of specific physical health conditions for people seeking asylum.[24] While all of those residing in initial accommodation should undergo an initial health assessment, these issues are not always followed up adequately, and people may face barriers in accessing care in the community.[25] Individuals claiming asylum may come to the UK with poorly controlled chronic health conditions, particularly if they have had extended journeys which have left them unable to access healthcare.[26] And although people seeking asylum in the UK are entitled to NHS care, there is evidence that the government's 'hostile environment' policies have resulted in deterring this group from healthcare, with reports of people being asked to demonstrate their entitlement to care or wrongly being charged or delayed care,[27] thus raising the likelihood that early intervention for COVID-19 management will be missed.[28]

Factors that increase risk of indirect health impacts

Studies suggest that people who are refugees – and in particular people in the asylum process – are more likely to face mental distress.[29] The prevalence of mental health conditions in individuals varies and is dependent on variables such as their migration journey, exposure to conflict and settlement conditions. Depression, anxiety and Post Traumatic Stress Disorder (PTSD) are the most commonly seen conditions in this cohort across the literature. Systematic reviews of mental health research carried out on asylum seeking and refugee populations in high income countries have found a broad range of prevalence of these conditions, with estimates for PTSD at around 9 per cent in the adult population[30] – although more recent studies give average estimates of around 40 per cent in those from conflict affected areas.[31]

Risk factors which can worsen mental health include experiences of trauma, a lack of social support, and greater stress after migration – all of which can be exacerbated due to the social distancing measures and restrictions on movement in place during the COVID-19 pandemic.

Factors that increase risk of socioeconomic impacts

As noted above, people seeking asylum are not permitted to work and are only eligible for very limited amounts of public funds. Moreover, there is evidence that some people will work without permission to avoid destitution, in precarious and sometimes exploitative work. This places them in a highly vulnerable financial situation during the COVID-19 pandemic. In addition, grassroots migrant support organisations are suspending face-to-face meetings due to the lockdown measures, and many people cannot afford digital technology, regular internet access or cellular phone data in order to stay virtually connected with these groups.[32]

People recently recognised as refugees

Size: From 2016 to 2019, we estimate that around 91,000 people were recognised as refugees		
Risk Factors	Risk of contraction	Overcrowded accommodation and multiple generations living under one roof; language barriers and limited available linguistically and culturally accessible public health messaging
	Risk of worse clinical outcomes	Higher likelihood of some long-term health conditions increases the possibility that individuals are immunocompromised or have worse prognosis of COVID-19
	Risk of indirect health impacts	Evidence of greater mental health needs
	Risk of socioeconomic impacts	Lower employment rates and earnings than average, and higher levels of self-employment; risk of gap in support due to delays in accessing Universal Credit (now appears to be temporarily addressed by government)

Overview

If their asylum application is successful, people are recognised as refugees. Our estimates suggest that approximately 26,000 positive grants of protection at initial decisions and after later appeals were granted in 2019.[ii] From 2016 to 2019, we estimate that around 91,000 people were recognised as refugees.[33] According to the Labour Force Survey, in 2018 there were around 58,000 people who said they originally came to the UK to claim asylum and who had been in the UK for five years or less (see Table 3.2).

[ii] This number includes our estimation of the number of dependants benefiting from positive appeal outcomes, based on the share of dependants in initial grants of protection or other leave.

Duration	Number	%
0–5 years	58000	16%
6–10 years	31000	9%
11–15 years	53000	15%
16–20 years	114000	32%
21–30 years	69000	19%
31 or more years	34000	10%

Table 3.2. How long have people who came to the UK to seek asylum lived in the country for? As at 2018

Source: Labour Force Survey, 2018 (weighted average of four quarters)
Notes: These data are for Great Britain only and do not include Northern Ireland. Includes participants

People with refugee status have permission to work in the UK and are entitled to the same benefits as UK citizens. Once they received their refugee status, under normal circumstances, people have their asylum support and accommodation terminated after 28 days. However, in the context of the current pandemic, the Home Office has suspended all evictions from asylum accommodation, including for those granted a positive asylum decision. Recently recognised refugees will continue to be paid asylum support beyond the 28-day limit until they receive their first payment of mainstream benefits.[34]

Factors that increase risk of contracting COVID-19

People recently recognised as refugees are more likely to live in overcrowded housing and are more likely to have multiple generations living together under one roof. Although entitled to social housing, they often enter the private rental sector due to shortages and often move multiple times in their first few years in the UK.[35] This can result in a sense of instability, reduced access to healthcare services, and a loss of community support. People may face prejudice when trying to secure housing due to policies such as the 'right to rent' scheme, which has been found to perpetuate racial discrimination in the rental housing sector.[36]

There are also specific language challenges for this cohort. The availability of key public health messaging in languages other than English has been variable, delayed or non-existent – with translation falling to NGOs and other community organisations. Additionally, such communications have not always been culturally and linguistically sensitive, potentially limiting their adoption by people recently recognised refugees.

Factors that increase risk of worse clinical outcomes from COVID-19

Pre-entry health assessment data for people entering under the refugee resettlement programme showed a high yield of Hepatitis B infection across this group. People with sub-Saharan African nationality tended to be at greater risk of several infections, notably HIV and Syphilis.[37] While there is no established link between these illnesses and COVID-19 contraction or disease course, there is a concern that should these individuals be immunocompromised – particularly in the context of barriers to healthcare – this will increase their risk of severe infection.

In addition, while refugees are eligible for free NHS care, there is evidence of them still being deterred from accessing care due to concerns over discrimination and challenges in registering with services.[38]

Factors that increase risk of indirect health impacts

As with those awaiting a decision on their asylum claim, this cohort has an increased prevalence of underlying mental distress and precipitating factors. People who originally sought asylum in the UK are more likely to report mental health problems compared with the UK born and other migrant groups.[39] This could be exacerbated during the COVID-19 pandemic.

Factors that increase risk of socioeconomic impacts

People who originally came to the UK to seek asylum are less likely to be employed than the UK born and other migrant groups, and on average they have lower earnings and work fewer hours. In the cases where they are in employment, they are also significantly more likely to be self-employed, placing them at greater risk of economic disruption due to the COVID-19 outbreak.[40]

There are also some immediate risks for people recently recognised as refugees. Generally, people lose their asylum support 28 days after being granted their refugee status, but could then face delays in accessing Universal Credit, leaving a gap in their financial support. However, the Home Office has now confirmed that asylum support payments will continue to be made until initial Universal Credit payments are started, although this is expected to only be a temporary arrangement.[41]

People whose asylum application has been refused

Size: Upper bound estimate of around 50,000 people who were refused asylum between 2010 and 2018 and may still be in the UK		
Risk Factors	Risk of contraction	Overcrowded and poor asylum accommodation and potential homelessness
	Risk of worse clinical outcomes	Charges for NHS secondary care in England (unless on government or local authority support); deterred from accessing care due to concerns about charging and immigration enforcement
	Risk of indirect health impacts	Evidence of greater mental health needs
	Risk of socioeconomic impacts	No legal permission to work and very limited support if destitute

Overview

If someone has been refused asylum and has exhausted their appeal rights, then they are advised by the Home Office to leave the UK, and – unless they have dependent children – their Section 95 support is stopped. By calculating the difference between the number of negative asylum outcomes and the number of voluntary and forced returns, we can provide an upper bound estimate of around 50,000 people who were refused asylum between 2010 and 2018 and may still be in the UK. (This estimate is likely to be upwardly biased, because some people who have had their asylum application refused may have since regularised their status or may have departed the UK without any records being taken.)[42]

In certain circumstances, people in this situation who are destitute can claim Section 4 support. This entitles them to accommodation and weekly payments of £35.39 paid through an ASPEN card. Around 4,000 people were receiving Section 4 support at the end of 2019 (see Table 3.1 above).

Some of the conditions that allow Section 4 support to be provided include "taking all reasonable steps to leave the United Kingdom" and being "unable to leave the United Kingdom by reason of a physical impediment to travel or for some other medical reason". Given most flights have been cancelled in the wake of the COVID-19 pandemic, there are therefore strong grounds for claiming Section 4 support if destitute.[43]

The Home Office has stated, as an emergency measure, that people on Section 95 support who lose this support because they receive a final rejection of their asylum claim will be automatically transferred onto Section 4 support. They have also said that all evictions from asylum accommodation are suspended and that support will not be discontinued for the next three months (unless the person is no longer destitute).[44]

Factors that increase risk of contracting COVID-19

For those with Section 4 support, there is evidence of overcrowding and limited facilities in asylum accommodation as discussed above. For those without Section 4 support, there is a risk of potential homelessness. Individuals who find themselves without shelter will face challenges in maintaining hygiene standards and practising social distancing. While the Home Office has said that this cohort is eligible for Section 4 support, in practice dispersals have largely been paused or delayed other than for some highly vulnerable or street homeless people.

In addition, for those on Section 4 support, all financial support is provided via an ASPEN card, which cannot be used to make online payments. This means they will often have little choice other than to leave their homes for basic necessities.[45]

Factors that increase risk of worse clinical outcomes from COVID-19

People who have been refused asylum are charged for secondary NHS care in England, unless they are receiving Home Office or local authority support (e.g. Section 4 or Section 95 support). In Scotland, Wales, and Northern Ireland, all healthcare is free for this cohort.

While treatment for COVID-19 infection has been declared as exempt from NHS charging, this information has not been widely publicised by the government in linguistically and culturally accessible ways. In any case, individuals may nevertheless be deterred from accessing healthcare, because they may be concerned about being billed for care should they test negative for COVID-19 or be treated for concurrent illnesses, or they may be fearful of immigration enforcement. Moreover, although people whose asylum claims have been refused are entitled to access to primary care, they face a myriad of barriers to registering with a General Practice.[46]

Factors that increase risk of indirect health impacts

As discussed with respect to the above cohorts, this cohort is particularly likely to face underlying mental health distress. In addition, those who have had their application for asylum refused will have the additional stress of delays to their claims due to increased processing times during the COVID-19 pandemic, as well as the fear of potential detention and deportation.

Factors that increase risk of socioeconomic impacts

People who have had their asylum application refused do not have legal permission to work and at most are only entitled to very limited support via an ASPEN card. Those who are not being accommodated due to delays in dispersal cannot access any financial support, given Section 4 accommodation and financial support are legally linked. This places this cohort in a particularly financially precarious position during the current pandemic. This cohort is also often dependent on charitable organisations that provide support in the form of finance, food and phone credit, many of which have closed or face challenges getting this support to their users.

Those who arrived as unaccompanied asylum-seeking children or adolescents

Size: Total number of 'looked-after' unaccompanied asylum-seeking children in England in 2019 was approximately 5000		
Risk Factors	Risk of contraction	Challenges for unaccompanied asylum-seeking children in large shared accommodation; language barriers could impede access to public health messaging
	Risk of worse clinical outcomes	No evidence of major risks identified; age group at relatively low risk
	Risk of indirect health impacts	Significant mental health risks – high prevalence of mental health conditions such as PTSD, anxiety, depression, and agoraphobia
	Risk of socioeconomic impacts	Pressures on local authority could deplete support services for this cohort; digital barriers could inhibit access to education, care, and community services

Overview

Some children and young people arrive in the UK seeking asylum and with no responsible adult to look after them.

Under the Children's Act 1989, local authorities have a responsibility to safeguard and protect the welfare of children in need (Section 17) and to provide accommodation for children who need a home because they have no-one with parental responsibility for them (Section 20). Generally, unaccompanied asylum-seeking children are accommodated under Section 20 of the Children's Act as 'looked after' children. The total number of 'looked-after' unaccompanied asylum-seeking children in England in 2019 was approximately 5000 (see table 3.3 below).

Local authority support for 'looked after' children includes accommodation (such as foster care or semi-independent accommodation for older children), financial support, allocation of social workers, immigration advice, and personal health and education plans.[47]

	2015	2016	2017	2018	2019
England	2,760	4,340	4,700	4,550	5,070

Table 3.3. Children looked after at 31 March, who were unaccompanied asylum-seeking children during the year

Source: SSDA 903 (Local authority tables, Table LAA4) Department of Education

Factors that increase risk of contracting COVID-19

For unaccompanied asylum-seeking children who are living in large shared accommodation, there is a higher likelihood of potential clusters of infection due to the number of shared communal spaces. Since the start of the pandemic, the government has acknowledged that it will be difficult for local authorities to make accommodation arrangements for large numbers of unaccompanied asylum-seeking children to self-isolate at any one time.[48]

There are also often language barriers for unaccompanied asylum-seeking children that may prevent them from getting the information they need to follow government advice. Depending on how long they have been in the UK, their capacity to communicate in English will vary. Where necessary, local authorities are meant to provide access to translation and interpretation services for unaccompanied asylum-seeking children, as well as access to ESOL support.

Factors that increase risk of worse clinical outcomes from COVID-19

We did not identify any major risk factors for this cohort. There are no available data on pre-existing health conditions of unaccompanied asylum-seeking children. Given they are under 18, they are considered to be a low-risk category for worse clinical outcomes from COVID-19. In addition, all looked after children are eligible for access to NHS care.

Factors that increase risk of indirect health impacts

There are significant mental health risks for this cohort. Studies show up to 50 per cent of unaccompanied asylum-seeking children present with mental illness such as PTSD, anxiety, depression, and agoraphobia.[49] Furthermore, PTSD symptoms are significantly higher among those in low-support living arrangements (e.g. living independently or semi-independently).[50] At the same time, unaccompanied asylum-seeking children face difficulties accessing mental health services due

to language and cultural barriers and a lack of awareness.[51] Despite this, many children have important coping strategies and effective control of trauma symptoms.[52]

The current crisis poses additional risks for unaccompanied asylum-seeking children. Known risk factors for mental illness in children include conditions such as social isolation, inadequate housing, and a loss of sense of identity and control. The pandemic could therefore potentially exacerbate some of the pre-existing mental health conditions among this cohort.

Factors that increase risk of socioeconomic impacts

While local authorities are under a statutory duty to safeguard and protect the welfare of unaccompanied asylum-seeking children, they face additional pressures during this pandemic which could jeopardise their support systems. Of importance are this cohort's access to education during school closures, access to continued support from social workers, and access to technology and internet connectivity. Many do not have access to internet or devices that connect to the internet; thus they could be unable to do schoolwork, speak to therapists or doctors via the internet or phone, or connect virtually with peers or other community services.[53] (Although looked after children are classed as 'vulnerable' and therefore allocated school places, reports indicate that only very small shares of vulnerable children are in attendance.)[54]

People in immigration detention

Size: As of 21 April 2020, there were 368 people in immigration detention in the UK		
Risk Factors	Risk of contraction	Detention facilities risk spread of COVID-19 – in particular due to shared cells and communal areas, poor hygiene standards and cleaning processes, and insufficient procedures for self-isolation
	Risk of worse clinical outcomes	Evidence of very poor health provision, including inadequate initial screening processes, delays in receiving treatment, and a lack of privacy in healthcare settings
	Risk of indirect health impacts	Evidence of significant mental health conditions among people in detention – including depression, anxiety, PTSD, self-harm and suicidal ideation
	Risk of socioeconomic impacts	Barring of visits by legal representatives will inhibit access to justice; no accommodation support for people after leaving detention could lead to destitution

Overview

Immigration detention is the Home Office practice of putting people in custody for immigration enforcement purposes. By law, people can only be detained for specific reasons – for instance, to examine someone's immigration status, where there are grounds for removal, or where a

deportation order is in force. People in detention cannot leave their detention centre (known as an Immigration Removal Centre) and their movements are severely constrained. There is no time limit on detention.

There are common law principles which guide the use of detention. According to these principles, detention should only be used when it is possible to deport detainees within a 'reasonable period' of time.[55] Under the current circumstances, where travel bans have been imposed by multiple countries and could last at least three to six months, the legal case for maintaining detention is weak. Indeed, after a legal challenge, the Home Office has already released 350 people and committed to urgently reviewing the remaining cases of all people held in detention.[56]

Since then, there have been further releases, and the latest figures from April indicate there are 368 people in immigration detention in the UK.[57] Based on data from past years, people in detention tend to be young and male.[58]

Factors that increase risk of contracting COVID-19

Detention centres pose a particular risk for COVID-19 transmission, as the virus has the potential to spread quickly once introduced by visitors or staff members.[59] Particular risks include shared cells and communal areas, poor hygiene standards and cleaning processes, and insufficient procedures for self-isolation.[60] There are also reports of a 'culture of disbelief' among staff, which inhibits adequate access to healthcare.[61]

Factors that increase risk of worse clinical outcomes from COVID-19

There is considerable evidence of very poor health provision in detention centres. According to evidence provided to the APPG Inquiry into the use of immigration detention in the UK, there are reports of inadequate initial screening processes, delays in receiving treatment and accessing medication, and a lack of privacy and confidentiality in healthcare settings.[62] Moreover, it is unclear whether there are processes for identifying people with underlying health conditions who are particularly vulnerable to COVID-19 within immigration detention.[63]

Upon release, there are reports of people who have been released not being given adequate housing or healthcare provision, including a lack of medication and follow up medical care.[64] Many GP surgeries are refusing to register new patients during the COVID-19 pandemic, leaving people bring discharged into the community without access to primary care. This is especially concerning for those managing pre-existing conditions and for those with medication needs.

Factors that increase risk of indirect health impacts

Many people in detention have existing mental health conditions, including high levels of depression, anxiety, PTSD, self-harm and suicidal ideation.[65,66] In addition, some of the COVID-19 control interventions taken to date – for instance, containing people in their cells – could have further damaging mental health implications for this cohort.[67]

Factors that increase risk of socioeconomic impacts

Due to the government's social distancing measures, there are no longer any visits taking place to detention centres, including visits by independent doctors and legal representatives. This has inhibited people in detention from accessing legal advice and healthcare.[68] Furthermore, for people

who are released from immigration detention as a result of COVID-19, there is no general provision for accommodation support; they are therefore at serious risk of destitution once released.[69,70]

People with leave to remain under the Destitution Domestic Violence (DDV) concession

Size: Unknown		
Risk Factors	Risk of contraction	Potential challenges for following government guidelines due to difficulties with temporary accommodation and limited interpreter support
	Risk of worse clinical outcomes	Entitled to free healthcare; however, the strict criteria for accessing this status could put people affected by domestic abuse at risk
	Risk of indirect health impacts	Increased risk of domestic violence during the pandemic; the strict eligibility criteria for this status means that people affected by domestic violence with insecure immigration status are at greater risk
	Risk of socioeconomic impacts	Strict eligibility criteria for this status puts people affected by domestic violence during pandemic at greater risk of destitution; specialist organisations could struggle to maintain levels of support during the crisis

Overview

Women with insecure immigration status who experience domestic violence are in a particularly vulnerable situation because generally they are subject to immigration control and have no eligibility for public funds. The Destitution Domestic Violence (DDV) concession intended to help people in this situation to access support. Being granted this status offers three months' leave to remain for people who came to the UK on a spouse/partner visa and whose relationship has broken down due to domestic violence. It is a temporary measure that gives people access to public funds, including Universal Credit and housing assistance while they are applying for permanent residence under the Domestic Violence Rule.[71,72]

The criteria for applying for this status are highly restrictive: only people who came to the UK on a spouse/partner visa are eligible. It is also strictly temporary and must be followed up by a full application for indefinite leave to remain.

Factors that increase risk of contracting COVID-19

People with DDV concession are eligible for housing support and many live in temporary accommodation.[73] While there is little information on the specific housing arrangements of this cohort, charities have raised concerns about the accommodation of domestic abuse survivors

during the pandemic and have called for the government to make alternative accommodation available through hotel chains.[74] There are also risks that people with this immigration status may face difficulties following government guidelines due to a lack of translation and interpretation provision, as there is evidence that women in this cohort who do not speak English are not provided with interpreter support.[75]

Factors that increase risk of worse clinical outcomes from COVID-19

There is no available data for the specific health status of this cohort. DDV concession holders are entitled to free NHS care, and there is also a charging exemption for treatment or services needed to treat people as a result of domestic violence. However, the eligibility criteria for the DDV concession is very restrictive. This is a potential barrier for those who have come to serious or repeated harm due to domestic violence and require medical treatment.

Factors that increase risk of indirect health impacts

There is evidence that the government's measures to limit the spread of the virus have led to a significant increase in domestic violence: the charity Refuge has seen a 700 per cent increase in traffic to its National Domestic Abuse Helpline website and the number of domestic abuse killings has doubled.[76,77] The limited nature of this immigration status could make it harder for people affected by domestic violence during the pandemic to seek support, given only those on specific visa routes are eligible.

There is also evidence that individuals affected by domestic violence, regardless of migration status, have increased prevalence of mental health conditions, including depression, anxiety and PTSD.[78]

Factors that increase risk of socioeconomic impacts

As previously noted, the restricted eligibility criteria for this status could make it harder for survivors of domestic violence to seek support during the pandemic. In addition, specialist support organisations – already under pressure before the COVID-19 pandemic – may struggle to provide sufficient levels of support due to additional demand, limited funds, and restrictions on movement and activity.

People without immigration status and children of people without immigration status

Size: Unknown		
Risk Factors	Risk of contraction	Risk of exposure at work due to lack of employment rights, unsafe conditions, and need to continue working; high risk of homelessness could heighten possibility of contraction
	Risk of worse clinical outcomes	No general entitlement to free NHS secondary care and barriers to accessing primary care; evidence that they could be deterred from accessing care for fear of charges and immigration enforcement
	Risk of indirect health impacts	Risk of heightened fear of approaching NHS in relation to other conditions; in addition, particularly vulnerable to domestic abuse due to fear of deportation
	Risk of socioeconomic impacts	No eligibility for public funds or right to work, which places this cohort at particular risk of destitution

Overview

Some people do not have legal permission to reside in the UK. This may be due to a number of reasons, such as overstaying a visa, having an asylum application denied, or entering the UK via an irregular route. This population is heterogeneous and includes groups such as stateless persons. The total number of people without immigration status is hard to estimate accurately because this cohort is not counted through any official administrative process and is unlikely to participate in a survey or official census.

People without immigration status are directly affected by the government's 'hostile environment' measures, which aim to make their lives as difficult as possible to encourage them to leave the UK. This means that people within this cohort are unable to legally work, rent, access healthcare, receive benefits, open a bank account, or apply for a driving license. There are also a number of data-sharing arrangements in place between the Home Office, other government departments and local authorities, which mean that where people without immigration status access certain services their information can be passed on to the Home Office for them to take immigration enforcement action.[79]

Factors that increase risk of contracting COVID-19

Without legal employment rights, people without immigration status are more likely to work in dirty, dangerous, or degrading jobs where they are more vulnerable to unsafe workplace conditions.[80] Given their financial precariousness, they might still be working during the pandemic in situations of informality with less access to personal protective equipment (PPE). Some people work in roles with close personal contact – such as care work or sex work – and thus could be at increased risk of exposure.

There is no robust evidence about the type of housing for people without immigration status. However, according to data on patients from Doctors of the World clinics – two thirds of whom are undocumented – more than 90 per cent of patients live in a personal or private flat.[81] Another study found that many people without immigration status rely for their accommodation on friends and associates.[82] Sofa surfing among this cohort is high; however, this is less viable now due to social distancing measures, with friends or associates unable to provide such accommodation support.

In the wake of the COVID-19 pandemic, charities have advised that numerous people without immigration status are currently, or will imminently, be street homeless. While the government has asked all local authorities to house people regardless of their immigration status, undocumented people may fear accepting accommodation in case they are subject to immigration enforcement. Additionally, they might be unable to access information on these services due to language barriers or a lack of access to the internet or digital devices. If provided with accommodation, there is a risk that these individuals will be moved away from their regular healthcare access point and related support infrastructure.

Factors that increase risk of worse clinical outcomes from COVID-19

People without immigration status are charged for secondary care, with all but 'urgent and immediately necessary' treatment billed upfront – i.e. before any healthcare is provided. Charging for secondary care is well documented to create a deterrent effect for undocumented people and for people within the immigration system more broadly, including for care that is exempt from charging (such as infectious diseases).[83] For those who have uncertain immigration status, one in three patients from Doctors of the World's clinics affected by healthcare charging said that they frequently or very frequently fear arrest when seeking healthcare.[84]

While people without immigration status have the right to access primary care services free of charge, studies suggest that many still face challenges accessing primary care.[85] People who have recently migrated to the UK tend to be less likely to be registered with a GP and, while data are limited, people who are undocumented are considered to have especially low rates of registration.[86,87] In one study by Doctors of the World of their patients – many of whom are undocumented – almost one in five attempts to register patients with a GP were refused.[88]

In the context of the COVID-19 pandemic, a lack of awareness of entitlements and fear of deportation and arrest could lead to delays in accessing care. Difficulties with GP registrations are likely to be exacerbated while the NHS is increasingly pressurised.[89] Many GP surgeries are now closed to new patients or incorrectly requesting photographic identification and/or proof of address to register, against NHS England guidance. Some GP surgeries have phone triage systems only available in English, further excluding people with limited English language capacity. Difficulties filling out HC1 forms (to access the NHS low income scheme) without English support or knowledge of NHS procedures could also hinder an individual's ability to access their entitlement to health.

Factors that increase risk of indirect health impacts

In the current crisis, there are reports emerging of people with conditions other than COVID-19 avoiding healthcare due to a fear of catching COVID-19 and placing an additional burden on NHS staff. This could be particularly acute for people without immigration status, due to fears of charging and immigration enforcement. In particular, research by Maternity Action has found that women affected by NHS charging are more likely to avoid care until a point of crisis.[90]

In addition, people without immigration status could be particularly susceptible to domestic abuse during the lockdown. A study in England showed that survivors of domestic abuse with insecure immigration status had a lack of information about rights and services and feared deportation if a pathway out of an abusive relationship was sought.[91]

Factors that increase risk of socioeconomic impacts

People who are undocumented are not eligible for public funds and do not have legal permission to work. Eighty-five percent of patients at Doctors of the World clinics live under the poverty line.[92] Losing income as a result of the pandemic could therefore have a critical impact on people without immigration status and their families. Moreover, many charities and other community support networks that normally provide food, health and social care support have suspended their face-to-face support, which could have major ramifications for undocumented people.

People who have been affected by trafficking and/or modern slavery

Size: Estimated 10,000-13,000 in 2013		
Risk Factors	Risk of contraction	For people currently being trafficked, no agency to stop work and seek protection; for survivors of trafficking, there are risks associated with shared and cramped accommodation
	Risk of worse clinical outcomes	For people currently being trafficked, access to healthcare could be restricted; for survivors of trafficking, they may not be identified by the NRM and so could be ineligible for free secondary care
	Risk of indirect health impacts	For people currently being trafficked, higher debt levels could force them into more dangerous work; for survivors of trafficking, risk that lockdown could trigger traumatic memories
	Risk of socioeconomic impacts	Very limited government support, combined with weaker support networks during pandemic, could force people into destitution

Overview

Modern slavery involves extreme forms of exploitation of other people and can include trafficking, as well as slavery, servitude, and forced labour.[93] Trafficking can be defined as the recruitment, transport, transfer, harbouring or receipt of people by force, fraud, coercion or deception, for the purposes of exploitation.[94] According to estimates from data collected in 2013, the number of people affected by modern slavery and trafficking in the UK is approximately 10,000-13,000.[95] The number of people referred into the National Referral Mechanism (NRM) as potential victims of modern slavery in 2018 was 10,672, a year-on-year increase of 52 per cent.[96] Many people affected by

modern slavery and trafficking do not have British citizenship. There are different arrangements for adults and children affected by modern slavery; here we focus on adults.

People affected by modern slavery and trafficking are entitled to government support. In order to access government support, they must enter the National Referral Mechanism (NRM). Those who enter the NRM and who receive a positive Reasonable Grounds decision (that is, are suspected of being a victim of modern slavery) are eligible for short-term support via the Victim Care Contract (VCC) for a Recovery Period of at least 45 days. This includes accommodation, translation and interpretation services, advice, and financial support. Financial support is limited to between £35 and £65 per week for adults with no dependents.

After the Recovery Period, there is a Conclusive Grounds decision (that is, a decision as to whether there are sufficient grounds to consider the person a victim of modern slavery). If positive, the person is given at least 45 calendar days of 'move-on' support, with more support if necessary, following the outcome of a Recovery Needs Assessment. If negative, the person is given nine working days of support. (These rules are for England and Wales; slightly different arrangements apply in Scotland and Northern Ireland.)[97]

People recognised as victims of modern slavery by the NRM are not necessarily granted leave to remain as a result of this decision. In some instances – for instance, where granting leave is required under the Trafficking Convention owing to their personal circumstances or where survivors are helping police with their enquiries – people will be eligible for Discretionary Leave, but this is not guaranteed.[98]

Factors that increase risk of contracting COVID-19

People who have been trafficked or forced into modern slavery are often trafficked for domestic servitude, sexual exploitation, or labour exploitation (such as agriculture, factory work, or car washing). The individual who has been trafficked will not have agency over their decision to work or travel or the ability to seek out personal protective equipment.

According to charities working with people affected by trafficking and modern slavery, around 80 per cent of people supported through the Victim Care Contract are in outreach support (i.e. not VCC accommodation).[99] Survivors are likely to be in a range number of accommodation types, such as supported housing, social services accommodation, asylum accommodation, the private rented sector, friends or family, or safe houses.[100] A number of charities have testified to housing situations that are often shared and cramped.[101] These circumstances would make effective self-isolation very difficult.

Factors that increase risk of worse clinical outcomes from COVID-19

Survivors have reported that, while being trafficked, traffickers had either restricted access to healthcare, accompanied them to appointments, or acted as interpreters during consultations.[102] At the same time, victims often do not seek healthcare due to concerns over being exposed to immigration enforcement.[103]

If an individual has been referred to the NRM and has received a positive conclusive grounds decision, or if they have received a positive reasonable grounds decision and are awaiting their conclusive grounds decision, they are exempt from NHS charging. However, around 30 per cent of those referred to the NRM in 2018 had by July 2019 received a negative reasonable grounds or conclusive grounds decision.[104] In addition, many people fear coming forward and are not referred to the NRM.[105] This leave a portion of this cohort unidentified and potentially exposed to the same

barriers as people without immigration status. There is also concern that difficulties in identifying those impacted by trafficking and modern slavery can be exacerbated by the encroachment of the hostile environment into healthcare settings, with individuals needing to feel safe and able to build trust with healthcare professionals prior to disclosure.

Moreover, research highlights that after escaping from exploitation people rely on support workers to access and use healthcare services and face barriers to care, including language difficulties, lack of identification, and limited familiarity with the NHS.[106,107]

Factors that increase risk of indirect health impacts

There is evidence of high prevalence of mental health conditions as a consequence of trafficking, including depression, anxiety, and PTSD.[108,109] According to the charity Unseen UK, the public health measures introduced as a result of COVID-19 could trigger traumatic memories and increase their vulnerability to harm. Without specialist counselling and therapy services – many of which are suspended under the current lockdown – there is likely to be a particularly acute impact on the mental health of survivors.[110]

In addition, as the economy is impacted by COVID-19, many people affected by forced labour could fall into further debt as work becomes less available, or potentially could end up working in sectors with higher levels of danger such as forced prostitution. They may also be less likely to be able to follow public health advice or utilise PPE while carrying out such forced labour. This could have impacts on their mental and physical health and their experiences of violence.[111]

Factors that increase risk of socioeconomic impacts

There is only very limited government support for survivors of trafficking – generally £35 per week for those in outreach accommodation. Furthermore, most charities and other community support networks that normally provide food, health and social care support such as childcare have suspended their face-to-face support. This could have major ramifications for survivors.

People from the Windrush generation

Size: In 2011 there were around 600,000 people living in the UK who were born in Commonwealth countries and arrived before 1971, and around 57,000 of these did not hold a UK passport. The latest figures show there are around 4000 people with outstanding cases with the Home Office's Windrush taskforce.		
Risk Factors	Risk of contraction	Many people in this cohort have previously worked in the NHS – government call for retired doctors and nurses to return to NHS could increase numbers working on the frontline
	Risk of worse clinical outcomes	High vulnerability due to age profile; and emerging evidence that people with Black Caribbean backgrounds are at particular risk; evidence of being incorrectly charged for care
	Risk of indirect health impacts	Evidence of pre-existing health conditions and physical/mental health impacts of Windrush scandal, which could be exacerbated by the pandemic
	Risk of socioeconomic impacts	People who have not had their status resolved could face barriers to accessing public services and benefits, exacerbating any financial issues caused by the pandemic, as well as further delays in accessing compensation

Overview

After the Second World War, the government encouraged people from the Commonwealth, largely from the Caribbean, to come to the UK to address labour shortages and help rebuild the British economy. They were known as the Windrush generation after one of the first ships, the Empire Windrush, that arrived from Jamaica in 1948. At the time, there were no restrictions on immigration from the Commonwealth. Those born in British colonies held UK citizenship; as colonies became independent, they often lost this status but still retained their free movement rights. In the 1960s and 1970s the government introduced new legislation to restrict immigration from the Commonwealth. In particular, the 1971 Immigration Act introduced a new system of immigration control. Those from the Windrush generation who were already present and settled in the UK in 1973 were granted the indefinite right to stay, but many were not given documentation to prove their status.[112]

As time passed, the government's 'hostile environment' measures – targeted at people without immigration status in the UK – began to have significant impacts on the Windrush generation and their children. Many who could not prove their status lost their jobs, could not access healthcare, and faced barriers to getting housing and benefits – despite living in the UK for decades or, in many cases, all their lives. Some were targeted by immigration enforcement and deported.[113] Eventually this emerged as a major scandal, and the government took measures to provide people with the right documentation and to offer compensation for those who has suffered as a result of the policy failures.[114] But many in the Windrush generation still have their status unresolved: the latest figures show there are around 4000 outstanding cases with the Home Office's Windrush taskforce.[115]

In total, it is unknown how many people have been affected by the Windrush scandal. However, Migration Observatory estimates suggest that in 2011 around 600,000 people living in the UK were born in Commonwealth countries and arrived before 1971, and around 57,000 of these did not hold a UK passport.[116]

Factors that increase risk of contracting COVID-19

The Windrush generation have made a major contribution to the running of the NHS since its foundation. While there are no conclusive data on the precise share of NHS workers from the Windrush generation, the government's call for retired doctors and nurses to return to the NHS to support the response to COVID-19 is likely to disproportionately affect this cohort, who could be at particular risk of contracting the virus through their work.[117]

Factors that increase risk of worse clinical outcomes from COVID-19

The older age profile of the Windrush generation places them as a high-risk cohort for experiencing more severe health impacts of the virus. There is also growing evidence that this cohort's ethnicity places them at a higher risk of mortality compared with the White UK population.[118] Evidence from the Labour Force Survey (see Section Five below) suggests that older BAME groups are more likely to have underlying health conditions and so could be particularly susceptible to worse clinical outcomes. Analysis from the IFS indicates that the number of per-capita hospital deaths due to COVID-19 in England among Black Caribbean people is nearly three times that of the White British population.[119] According to the ONS, the risk of deaths in England and Wales related to COVID-19 among Black people is around twice that of White people, after controlling for socio-demographic factors and self-reported health and disability.[120] The reasons for this are currently unknown, but are likely to be complex and involve several structural and socio-economic factors, as discussed in Section Two.

In addition, some people from the Windrush generation may continue to face barriers to accessing secondary healthcare due to their status being left unresolved.

Factors that increase risk of indirect health impacts

Health campaigners have found evidence that a number of people from the Windrush generation have suffered significant physical and mental health consequences as a result of their experiences in the immigration system and the effects of the 'hostile environment'. There are reports of hypertension and strokes, attempted suicides, anxiety and depression, and loneliness.[121] During the current pandemic, there is a risk that these conditions could be exacerbated – both due to people from this cohort not seeking healthcare treatment for underlying conditions for fear of contracting COVID-19 and because of the broader mental health impacts associated with restrictions in movement and activities. For people who have not yet had their cases resolved, the current crisis could add to their feelings of uncertainty and anxiety.

Factors that increase risk of socioeconomic impacts

People from the Windrush generation who have not yet had their legal status resolved could continue to face barriers to accessing public services and benefits during the pandemic. Given the age demographic of this cohort, many individuals will be expected to be 'shielding', which could make them particularly reliant on government support – those who face barriers in accessing this

support could be forced to go against public health advice, putting them at risk of contracting COVID-19.

More broadly, there is a risk that the COVID-19 crisis distracts from the challenges faced by the Windrush generation and the Home Office's policy and operational failures: the recent Windrush Lessons Learned review was published at the height of the crisis and so received notably less attention than originally expected.[122] Many people are still waiting for compensation claims to be processed, adding to hardship.

People who hold work visas (Tier 2 General)

Size: Total number of people with valid leave to remain in 2016 under the Tier 2 work route, for those issued visas between 2004 and 2016, was around 280,000.		
Risk Factors	Risk of contraction	Very large share of Tier 2 (General) visas are for nurses and medical practitioners
	Risk of worse clinical outcomes	No evidence of specific risks for this cohort; access to NHS and likely to be aged under 50
	Risk of indirect health impacts	Those who lose their jobs may be at greater risk of mental health difficulties due to anxieties over immigration status
	Risk of socioeconomic impacts	Potentially at greater risk of redundancy due to restrictive visa conditions; no access to public funds such as Universal Credit

Overview

The Tier 2 (General) visa is the UK's main work visa for "skilled" workers. It is a temporary work visa which lasts up to five years and is subject to strict occupational restrictions and salary thresholds. It is a sponsored visa which ties the visa holder to their employer. At the end of 2016, the total number of people with valid leave to remain under the Tier 2 work route, for those issued visas between 2004 and 2016, was around 280,000. (This includes both main applicants and dependants.)[123]

The visa only permits individuals to work in their sponsored job; a second job is only permitted for a maximum of 20 hours per week and must be in the same profession and level as the main job or on the Shortage Occupation List.[124]

The government has introduced a number of emergency measures in response to the Coronavirus pandemic that affect people who hold Tier 2 visas – in particular, the government has said that some frontline health workers whose visas expire before October will have their visas extended for one year.[125] (This measure does not just apply to Tier 2 visa holders; all those with temporary visas could be eligible.)

Factors that increase risk of contracting COVID-19

Among Tier 2 (General) visa holders, there is a very high concentration of people working in the NHS. Home Office figures indicate that 22 per cent of restricted certificates of sponsorship used in 2018 under the Tier 2 (General) route were for nurses and 17 per cent were for medical practitioners.[126] Nurses and doctors are on the frontline in the response to Coronavirus and are at manifestly higher risk of contracting COVID-19.

Factors that increase risk of worse clinical outcomes from COVID-19

There is no specific evidence on the risks for this cohort. Tier 2 (General) visa holders have access to the NHS (though must pay an immigration health surcharge as part of their application) and they and their dependants tend to be aged under 50.[127]

Factors that increase risk of indirect health impacts

Tier 2 (General) visa holders who lose their jobs could be at particular risk of mental health difficulties as a result of anxiety over their immigration status and their limited social safety net.

In addition, there were until recently no specific provisions for dependants of Tier 2 visa holders working in the NHS to retain their status in the UK if their family member passed away due to contracting COVID-19.[128] This could have had serious implications for bereaved family members, creating additional anxieties under already distressing circumstances. However, the Home Office has now stated that leave to remain will be freely granted to all dependants in these circumstances.[129]

Factors that increase risk of socioeconomic impacts

People who hold Tier 2 (General) visas in affected sectors are potentially at greater risk of redundancy, because the requirements of their visa mean that there are fewer options for employers to avoid making them redundant (though the Home Office has partially relaxed the rules to allow employers to temporarily pay lower salaries). Similarly, if they lose their job it could be harder for them to find alternative employment, due to the need to find a new sponsor and to meet the relevant occupational and salary thresholds. Those who do not find alternative work risk losing their right to stay in the UK. The visa also includes a 'No Recourse to Public Funds' condition, so people holding these visas are not entitled to housing assistance or benefits such as Universal Credit if they lose their jobs. (However, they are still eligible for the government's job retention scheme.)

People who hold study visas (Tier 4 General)

Size: Total number of people with valid leave to remain in 2016 under the study route, for those issued visas between 2004 and 2016, was around 480,000.		
Risk Factors	Risk of contraction	Likely to be living in shared accommodation and may be harder for international students to return home
	Risk of worse clinical outcomes	No evidence of specific risks for this cohort; access to NHS and likely to be young
	Risk of indirect health impacts	No evidence of specific risks for this cohort
	Risk of socioeconomic impacts	Limited social safety net – no access to public funds such as Universal Credit

Overview

The Tier 4 (General) visa is the main route for people to come and study from overseas in the UK. This is a temporary visa which lasts up until the end of the course (plus up to four months depending on the length of the course). At the end of 2016, the total number of people with valid leave to remain under the study route, for those issued visas between 2004 and 2016, was around 480,000. (This includes both main applicants and dependants.)[130]

The Tier 4 visa places restrictions on how much people can work, depending on their course type. Full-time degree students are permitted to work for a maximum of 20 hours per week during term time.[131]

Some of the government's emergency response measures in light of the Coronavirus pandemic have particular implications for study visa holders. For instance, the Home Office has removed the limit on working hours for students who are working for the NHS as a doctor, nurse or paramedic.[132]

Factors that increase risk of contracting COVID-19

Regardless of immigration status, students are particularly likely to be living in shared accommodation, increasing the risk of transmission. Moreover, unlike domestic students, international students may not be in a position to return home easily.

Factors that increase risk of worse clinical outcomes from COVID-19

There is no specific evidence on the risks for this cohort. People on these visas have access to the NHS (though must pay an immigration health surcharge as part of their application) and the majority are aged under 30.[133]

Factors that increase risk of indirect health impacts

There is no specific evidence on the risks for this cohort.

Factors that increase risk of socioeconomic impacts

Student visa holders have a NRPF condition, so they are not entitled to housing assistance or benefits such as Universal Credit if they lose part-time work and cannot fall back on alternative income or savings. For those who cannot return home, the current pandemic risks forcing them into destitution. In particular, there are reports of Indian students in the UK relying on emergency food drops because they have lost work and cannot meet essential living costs, yet are trapped in the UK due to the Indian government's flight ban.[134]

People who hold seasonal worker visas

Size: Around 2500 visas were issued under the Tier 5 Seasonal Worker category in 2019		
Risk Factors	Risk of contraction	Risk of transmission during travel via charter flights or when working in the UK, due to poor housing conditions and limited employment rights
	Risk of worse clinical outcomes	General charges for secondary healthcare could deter people from seeking help
	Risk of indirect health impacts	No evidence of specific risks for this cohort
	Risk of socioeconomic impacts	Cohort could be overworked and exploited by unscrupulous employers – particularly given restrictive visa conditions and no access to public funds

Overview

The government has introduced a pilot immigration scheme for seasonal agricultural workers under the Tier 5 Seasonal Worker visa. This is a temporary visa that lasts up to 6 months and allows people to work in the horticulture sector. The visa only permits people to work in the job specified on their certificate of sponsorship and, while workers can ask to switch employer, they are not guaranteed the right to switch.[135,136] Around 2500 visas were issued under the Tier 5 Seasonal Worker category in 2019 and the number of available visas this year is 10,000.[137] Visa holders largely came from Ukraine, Moldova and Russia. While many seasonal workers are from EU countries, they do not need visas given free movement rules apply; this scheme is therefore currently only designed for non-EU citizens.

In light of the Coronavirus pandemic, travel disruptions have jeopardised the migration of seasonal workers and led to fears among farmers of labour shortages over the summer period. A number of labour recruiters are organising or considering organising charter flights in response – currently there are charter flights from Romania, an EU member, but these may be extended to countries such as Ukraine where the seasonal worker scheme would apply.[138]

Factors that increase risk of contracting COVID-19

If people come to the UK on the seasonal worker visa this year, they are potentially at high risk of contracting the virus – both during their travel to the UK and while they are working on farms, due to poor housing conditions and proximity between workers.[139,140] Moreover, the restrictive conditions attached to this visa – the difficulty with switching employers and the limited rights to public funds and services – mean that people in this category are vulnerable to abuse and could be particularly exposed to unsafe working conditions.[141]

Factors that increase risk of worse clinical outcomes from COVID-19

As short-term workers that do not pay the immigration health surcharge, seasonal worker visa holders do not have a general legal entitlement to free secondary healthcare. This could deter this cohort from seeking healthcare due to the fear of being charged for treatment. (However, it is expected that they will be provided with private health insurance by their labour providers.)[142]

Factors that increase risk of indirect health impacts

There is no specific evidence on the risks for this cohort.

Factors that increase risk of socioeconomic impacts

Desperation for agricultural labourers during the current crisis could result in people who are Tier 5 seasonal workers being overworked and exploited. This cohort is at particular risk of exploitation given the restrictions attached to their visa and their lack of access to public funds.[143]

People who hold domestic worker visas

Size: Around 21,000 visas were issued for people doing domestic work in private households in 2019		
Risk Factors	Risk of contraction	Often live with and in close contact with employers; evidence of poor treatment and abuse, which could make it harder to follow government guidelines
	Risk of worse clinical outcomes	Unscrupulous employers may not live up to their responsibilities to ensure free access to medical treatment; lack of information and employment rights could make it hard to seek primary care
	Risk of indirect health impacts	Particularly vulnerable to physical, sexual and verbal violence; risk of violence and abuse heightened due to the pandemic
	Risk of socioeconomic impacts	Precarious economic situation due to reliance on employer and no access to public funds; risk of being evicted by employer

Overview

The domestic worker visa is for people who work as domestic workers in a private household, including cleaners, cooks and nannies. It is used for domestic workers who visit the UK with their employers temporarily and intend to work in a household in which their employer lives.[144] There were around 21,000 visas issued for domestic workers in private households in 2019.[145]

People on domestic worker visas are subject to tight restrictions. The visa lasts only for six months and cannot usually be extended, though victims of modern slavery or human trafficking are eligible for extensions of up to two years.[146] While in the past, people could not switch employers, now they may do so provided they are still working as in a private household.[147] However, in practice it is very hard to switch employers, because of the non-extendable six-month visa length.[148]

Factors that increase risk of contracting COVID-19

People who hold domestic worker visas often live with their employers as nannies, carers and cleaners, and so may be at particular risk of contracting the virus due to close contact with other members of their household. Moreover, there is extensive evidence that people on these visas in many cases face poor treatment from their employers, including abuse and exploitation, which could make it particularly hard to follow government guidelines and adequately protect themselves from the virus.[149]

Factors that increase risk of worse clinical outcomes from COVID-19

As short-term workers that do not pay the immigration health surcharge, people holding domestic worker visas are not legally entitled to free secondary care and their employer is responsible for ensuring they have free access to medical treatment.[150] Unscrupulous and exploitative employers could therefore impede people from accessing free healthcare.

There is also evidence that people here as domestic workers lack information about their entitlement to primary care and face barriers in registering with GPs. According to testimony from Doctors of the World, people are in many cases not given sufficient time off by their employers to visit and register with GPs, and they may be wrongly refused by GPs when they try to register.[151]

Factors that increase risk of indirect health impacts

People here as domestic workers are particularly vulnerable to violence, abuse and exploitation. In a survey conducted in 2019, 59 per cent of participants reported experiencing abuse at work – including most commonly physical abuse, as well as verbal and sexual abuse.[152] Given the pandemic requires largely staying indoors and many domestic workers live with their employers, the risk is currently particularly high for this cohort.

Factors that increase risk of socioeconomic impacts

Many domestic workers are in financially precarious situations and are highly reliant on their employer for their housing and income. The Voice of Domestic Workers has reported that some employers are evicting their domestic workers in response to the COVID-19 pandemic, potentially leaving them destitute.[153]

People holding domestic worker visas also have a 'No Recourse to Public Funds' condition attached to their visa and so are not entitled to housing assistance or benefits such as Universal Credit. Some

may be compelled by their employers to overstay their visas, leaving them undocumented and so more vulnerable to the socioeconomic impacts of COVID-19.[154]

People who hold family visas

Size: Total number of people with valid leave to remain in 2016 under the family route, for those issued visas between 2004 and 2016, was around 180,000.		
Risk Factors	Risk of contraction	Language barriers could make it harder to follow government guidance
	Risk of worse clinical outcomes	No evidence of specific risks for this cohort; access to NHS care and likely to be aged under 50
	Risk of indirect health impacts	No evidence of specific risks for this cohort
	Risk of socioeconomic impacts	No access to public funds, minimum income requirement and high visa extension fees put this cohort at risk

Overview

Family visas allow people to come to the UK and stay with family members for more than 6 months. They also provide the right to work and study in the UK. At the end of 2016, the total number of people with valid leave to remain under the family route, for those issued visas between 2004 and 2016, was around 180,000.[155]

The precise rules attached to a family visa depend on whether it is for people coming as a partner, a parent, or a child. For partners and parents, they must apply for a temporary visa with an initial length of 2.5 years, which can be extended and then converted into indefinite leave to remain after five or ten years. For partners, there is a minimum income requirement as part of the application process: the applicant's sponsor – i.e. their partner – must earn at least £18,600 a year before tax (or alternatively the requirement can be met in other ways, such as through savings).

There is also the option for people who have lived in the UK for a long time (for instance, people aged under 18 who have lived in the UK continuously for at least seven years) to apply for leave to remain on the basis of their private life. This route grants limited leave to remain in 2.5 year periods until individuals have secured 10 years of this residency and are granted indefinite leave to remain.[156]

Factors that increase risk of contracting COVID-19

There is some evidence from a 2011 Home Office study that people coming to the UK on family visas may on average face greater English language barriers compared with other migrants.[157] This cohort may therefore face particular challenges accessing government information on Coronavirus.

Factors that increase risk of worse clinical outcomes from COVID-19

There is no specific evidence on the risks for this cohort. People holding family visas have access to the NHS (though must pay an immigration health surcharge as part of their application) and tend to be aged under 50.[158]

Factors that increase risk of indirect health impacts

There is no specific evidence on the risks for this cohort.

Factors that increase risk of socioeconomic impacts

People holding family visas have a 'No Recourse to Public Funds' condition, so they are not entitled to housing assistance or benefits such as Universal Credit. This places them at significantly higher risk of destitution if they are made redundant as a result of the COVID-19 pandemic. In addition, they are also subject to the minimum income requirement and high fees for visa extensions. For those who suffer hardship due to the pandemic, these requirements could make it difficult to extend their leave to remain.[159]

People who are EU citizens

Size: Around 3.4 million people (excluding Irish citizens)		
Risk Factors	Risk of contraction	High numbers of 'key workers' in food manufacturing, where there are reports that virus can spread quickly; more likely to live in overcrowded accommodation
	Risk of worse clinical outcomes	Generally likely to be healthier than UK citizens and should have access to free healthcare; however, also more likely to be smokers
	Risk of indirect health impacts	Stress and anxiety related to end of free movement could be exacerbated
	Risk of socioeconomic impacts	Closure of EU Settlement Resolution Centre and grassroots services likely to make it harder to secure settled status; for people without settled status, Habitual Residence Test could restrict access to housing assistance and benefits such as Universal Credit

Overview

Under free movement rules, people who are EU citizens have the right to live, work and study in the UK. There are around 3.4 million EU citizens living in the UK, excluding Irish citizens.[160]

EU citizens have an initial 'right to reside' in the UK for three months. In addition, they can have a right to reside for longer periods as a worker or self-employed person, a student, a 'self-sufficient' person, or a jobseeker. Family members of EU citizens with a right to reside in the UK are also

granted a right to reside. After five years of legal and continuous residence in the UK, EU citizens automatically secure a permanent right to reside. Under EU law, EU citizens should be granted equal treatment to UK citizens – though there are some limits on access to benefits, as discussed below.[161]

The UK is set to end freedom of movement once the transition period ends at the end of 2020 (though the transition period may be extended in light of the COVID-19 pandemic). At this point, newly arriving EU citizens will no longer have the same rights to live, work and study in the UK. However, EU citizens already living in the UK should maintain these rights under the EU-UK Withdrawal Agreement. To guarantee their rights, EU citizens are required to apply to the Home Office's EU Settlement Scheme. EU citizens who have been in the UK continuously for at least five years should be granted 'settled status', which is the equivalent of indefinite leave to remain. EU citizens who have been in the UK for less should be granted 'pre-settled status' – this is limited leave to remain, which can then be transferred to 'settled status' once they have been in the UK continuously for five years.[162] At the end of March 2020, there had been 3.1 million concluded applications to the EU settled status scheme, with 58 per cent of these being granted settled status and 41 per cent pre-settled status.[163]

Factors that increase risk of contracting COVID-19

People who are EU citizens make up a significant proportion of 'key workers' in sectors such as food manufacturing and distribution. Around a quarter of people working in the food manufacturing sector are EEA migrants, largely from the new EU member states.[164] These people are therefore likely to be working out of home and will be potentially at increased risk of exposure to COVID-19. Reports from Germany suggest that the virus has spread quickly among workers in slaughterhouses.[165]

People who are EU citizens are also more likely than average to live in overcrowded accommodation and in the private rented sector.[166] This could make it harder to follow the government's social distancing guidelines and put them at particular risk of contraction.

In London, a large proportion of people who were rough sleepers (an estimated 30 per cent) are citizens of Central and Eastern Europe.[167] While the government has asked local authorities to provide accommodation for all who are roofless during the COVID-19 pandemic, there are reports that some have not been accommodated and so are at high risk of contraction.[168]

Factors that increase risk of worse clinical outcomes from COVID-19

People who are EU citizens have free access to healthcare in the UK (provided they are ordinarily resident).

Evidence from the Labour Force Survey indicates that EU citizens report having lower rates of limiting and non-limiting health problems compared with UK citizens. (although this health advantage reduces in proportion to their time spent in the UK.) However, there is a higher rate of smoking among both male and female EU citizens, which is thought to result in worse outcomes from COVID-19 infection.[169]

Factors that increase risk of indirect health impacts

There are some reports that the UK's withdrawal from the EU and the end of freedom of movement have led to a rise in stress and anxiety among EU citizens concerned over their immigration status.[170]

The uncertainty experienced during the COVID-19 pandemic – and the implications of the lockdown for applying to the EU Settlement Scheme – risk exacerbating these mental health issues for some groups.

Factors that increase risk of socioeconomic impacts

Due to the closure of the government's EU Settlement Resolution Centre and many grassroots support services, there is a significant risk that EU citizens will find it harder to apply to the EU Settlement Scheme in time for the deadline and may therefore become undocumented after the deadline passes.

At the same time, many EU citizens – particularly those who have been made redundant or lost work due to COVID-19 – may struggle to access housing assistance or benefits such as Universal Credit. This is because in order to access such benefits and support, EU citizens must pass the Habitual Residence Test – including proving that they have a 'right to reside' in the UK. While those who have been granted settled status can use this as proof of right to reside, EU citizens who have not yet applied or who have pre-settled status will need to prove their right to reside in the standard way – for instance, by demonstrating that they are a 'retained worker' because they have been made involuntarily unemployed after a period of 'genuine and effective' work. Certain forms of right to reside – such as the right to reside as a jobseeker – do not grant access to benefits such as Universal Credit.[171] The advocacy group the3million has argued that these restrictions on benefits for people with pre-settled status contravene the EU-UK Withdrawal Agreement.[172]

People who are carers, with a derivative right to reside

Size: Between January 2012 and June 2018, around 1700 people were recognised as having a derivative right to reside		
Risk Factors	Risk of contraction	No specific evidence on the risks for this cohort
	Risk of worse clinical outcomes	No specific evidence on the risks for this cohort; eligible for free healthcare
	Risk of indirect health impacts	No specific evidence on the risks for this cohort
	Risk of socioeconomic impacts	Zambrano / Chen carers are not eligible for housing assistance or benefits such as Universal Credit

Overview

Some people qualify for derivative rights of residence through EU law – typically non-EU primary carers via the free movement rights of a child. The different types of derivative rights to reside include:

- Zambrano carers: the primary carer of a UK citizen (a child or dependent adult) where, if denied the right to stay in the UK, this would force the UK citizen to leave the UK/EU.

- Chen carers: the primary carer of a self-sufficient EU child, where if denied the right to stay in the UK this would prevent the child from exercising their free movement rights.
- Ibrahim/Teixeira carers: the child of an EU worker or former worker who is in education in the UK, as well as their primary carer, where if denied the right to stay in the UK this would stop the child from continuing education in the UK.[173]

In the period between January 2012 and June 2018, around 1700 people were recognised as having a derivative right to reside.[174]

Factors that increase risk of contracting COVID-19

There is no specific evidence on the risks for this cohort.

Factors that increase risk of worse clinical outcomes from COVID-19

There is no specific evidence on the risks for this cohort. Provided they are ordinarily resident, this cohort does have the right to free access to secondary healthcare, as the derivative right to reside is considered a legal form of residence.[175]

Factors that increase risk of indirect health impacts

There is no specific evidence on the risks for this cohort.

Factors that increase risk of socioeconomic impacts

Zambrano and Chen carers are generally not eligible for housing assistance or for benefits such as Universal Credit. (Ibrahim/Teixeira carers, on the other hand, are eligible.)[176] This makes them particularly vulnerable to the economic impacts of the pandemic.

Box 3.1: Extensions of leave

The government has introduced provisions for people on a temporary visa that is due to expire and who cannot leave the UK due to current travel restrictions or self-isolation requirements. If they are in this situation, individuals can apply to the Home Office to have their leave extended until the end of May. However, this is not an automatic extension policy – it still requires people to apply – and some experts have questioned its legal basis. Those who wish to stay in the UK for the long term will still need to apply for a long-term visa in the standard way and meet the usual eligibility requirements (though they can now apply from within the UK in all cases).[177]

4. The socio-economic impact of the COVID-19 pandemic on people who are not UK citizens

In this section we explore in more detail the socio-economic risks of COVID-19 on people in the immigration system. It is not possible to have detailed information about the socio-economic characteristics of each of the cohorts described in Section Three because surveys do not include questions on legal immigration status. Nonetheless, most surveys do ask respondents about their citizenship, country of birth and year of migration to the UK. We use this information to describe the economic situation of recent non-EU citizens, many of whom are likely to have been granted limited leave to remain with a condition of NRPF attached to their legal status, as well as the economic situation of recent EU citizens, who are likely to have pre-settled status (rather than settled status).

The data presented in this section will therefore show the demographic and economic characteristics of people who have been in the UK for up to five years and those who have been living here for longer. We also show data for UK citizens, distinguishing between those who are Black, Asian, and minority ethnic (BAME) and those who place themselves in any of the 'White' ethnicity categories. Note that a third (35 per cent or 2,395,000) of UK citizens who self-identify as BAME were born in a country outside the EU (see table A.1 in Annex A).

The reasons for migration to the UK are different for EU and non-EU citizens. Among citizens from countries outside the EU, about 40 per cent said that their main reason for migration to the UK was to accompany or join a family member and about 20 per cent said it was for work, while more than half of the EU citizen population moved to the UK mainly for work-related reasons.[178] Note, however, that the main reason for migration to the UK does not necessarily coincide with people's legal migration status, although there is some overlap.[iii]

The content of this section is organised as follows. First, we provide some descriptive data about the nationality and age distribution of the non-UK citizen population. Second, we present data on the economic situation of non-UK citizens, paying special attention to indicators of economic vulnerability. Third, we provide evidence of the differential economic impact that the pandemic is having on vulnerable non-UK citizens.

[iii] Unfortunately we cannot provide breakdowns by reason of migration because this data can only be analysed remotely from our organisational desktop, to which we do not currently have access.

How many years have non-UK citizens been living in the UK?

Table 4.1 shows the number of UK, EU and non-EU citizens living in the UK in 2019. About 41 per cent (1,014,000) of non-EU citizens and 29 per cent (1,118,000) of EU citizens have been in the UK for up to five years. Most of them will have either leave to remain with NRPF (non-EU citizens) or pre-settled status (EU citizens). The actual number could be slightly higher given that survey-based estimates are likely to understate the size of the recent non-UK population.

	UK citizen		EU citizen		Non-EU citizen		Total	
	In 1000s	%	In 1000s	%	In 1000s	%	In 1000s	%
UK born	55,837	94%	523	14%	137	6%	56,497	86%
Foreign born In the UK for up to 5 years	168	0%	1,118	29%	1,014	41%	2,300	4%
Foreign born In the UK for +5 years	3,505	6%	2,241	58%	1,344	54%	7,090	11%
Total population	**59,511**	**100%**	**3,882**	**100%**	**2,495**	**100%**	**65,887**	**100%**

Table 4.1. Place of birth and time in the UK of UK, EU and non-EU citizens (all ages), 2019
Source: Annual Population Survey 2019

What is the citizenship of the foreign-born population in the UK?

Almost half of the foreign-born population who have been in the UK for up to five years are EU citizens (49 per cent or 1,118,000) and 44 per cent (1,013,000) are non-EU citizens (see Table A.2 in Annex A). Among citizens from non-EU countries who have been in the UK for up to five years, the largest share corresponds to Indian citizens (205,000), many of whom are students. Around 13 per cent (300,000) of the foreign-born with a shorter residence in the UK hold a citizenship from 'other countries', which mainly includes citizens of non-EU European countries as well as of North, Central and South America.

What is the age distribution of non-UK citizens?

The age distribution of non-UK citizens who have been in the UK for up to five years is younger compared to those who have been residing in the UK for longer (see Table A.3 in Annex A). For example, more than half of non-EU citizens (51 per cent) and EU citizens (55 per cent) who have been in the UK for up to five years are between the ages of 18 and 34, while this share is much lower among those who have been in the UK for a longer period (25 per cent for non-EU citizens and 26 per cent for EU citizens).

What is the economic profile of non-UK citizens?

EU citizens who have a short residence tend to be in employment compared to those with longer residence: 74 per cent of male EU citizens and 67 per cent of female EU citizens who have been in the UK for up to five years are in employment, compared with 62 per cent of male EU citizens and 61 per cent of female EU citizens who have been in the UK for longer. On the other hand, non-EU

citizens with a short resident are more likely to be students than non-EU citizens with longer residence (see Table A.4 in Annex A). Some of the differences between non-UK citizens with shorter and longer residence in the UK (e.g. in the share of employed population) are explained by the fact that those who have been in the UK for up to five years tend to be younger and hence more likely to be employed (see Table A.5 in Annex A for a breakdown of 16-24 year olds only).

Which workers are more at risk during the COVID-19 pandemic?

The measures that governments have put in place to contain the COVID-19 pandemic have had an unprecedented impact on the economy.[179] As a result, many people have lost their jobs or experienced substantial losses in their earnings, particularly those working in the sectors that have been required to close. According to a recent study, the unemployment rate in the UK will likely rise to 20 per cent by the end of May, an increase that is similar to that reported for the US.[180,181] Using 2020 data for the UK and the US, economists have shown that people who cannot do their jobs from home and those working in shutdown sectors are at a high risk of unemployment.[182,183]

Crucially, the economic impact of this crisis appears to be highly unequal across workers and economic sectors. The available preliminary evidence suggests that the current crisis has exacerbated the vulnerability of people who were already in a precarious economic situation before the pandemic (e.g. people in low-paid and insecure jobs, many of whom are non-UK citizens). For example, a large share of people working in the hospitality and accommodation sectors, which have been forced to close to contain the spread of the virus, are in low-paid jobs (65 per cent, based on authors' calculation using the Annual Population Survey (2019).)[iv] According to recent research, people who can perform a higher share of their job tasks from home have on average higher earnings than those who don't.[184,185] This means that, at least in the short term, the economic shock caused by the pandemic is likely to increase inequalities between higher- and lower- paid people.

Which groups were economically vulnerable before the COVID-19 pandemic?

People living in households where all their members are unemployed, or who are in insecure and/or low-paid jobs were already in a vulnerable economic position before the current crisis.

In 2019, 41,000 non-EU citizens who had been in the UK for up to five years lived in households where all their active[v] members were unemployed (see Table A.6 in Annex A). The number is similar (43,000) for those non-EU citizens who had been residing in the UK for a longer period.

In other cases, people have employment contracts but no guaranteed hours or income. Zero-hour contracts are those where employers are not obliged to give workers a minimum number of working hours and they are common in the hospitality, care and health sectors.[186] About a third of people on zero-hours contracts work in low-paid service occupations (e.g. kitchen assistants or waiters) or as care workers (authors' estimations based on Labour Force Survey (2019)). Among citizens from non-EU countries, 12,000 of those who migrated during the last five years and 25,000 of those

[iv] Most low-paid jobs are low-skilled or low-medium skilled jobs. The classification of jobs as low or high skilled is based on the four-category classification developed by the ONS in 2010. In this context, job skills mainly indicate the educational credentials that are required to perform a job and do not consider other types of personal skills that are valued in the labour market, such as soft skills.

[v] The active population refers to people who are in employment (employees, self-employed or in government training programmes) or unemployed. The inactive population includes children under age 16, full-time students, retirees, and those who are looking after their families.

who had been in the UK longer were on zero-hour contracts in 2019 (see Table 4.3). The share of workers in this type of contract was the highest among EU citizens who moved to the UK during the last five years (6 per cent or 31,000).

	Non-EU citizens				EU citizens				UK citizens			
	In the UK for up to 5 years		In the UK for +5 years		In the UK for up to 5 years		In the UK for +5 years		BAME UK citizens		Non-BAME UK citizens	
	In 1000s	**%**	**In 1000s**	**%**	**In 1000s**	**%**	**In 1000s**	**%**	**In 1000s**	**%**	**In 1000s**	**%**
Non-zero-hour	354	97%	626	96%	525	95%	1,283	98%	2,072	96%	20,357	97%
Zero-hour	12	3%	25	4%	31	6%	32	2%	80	4%	561	3%
Total	**365**	**100%**	**651**	**100%**	**556**	**100%**	**1,315**	**100%**	**2,152**	**100%**	**20,918**	**100%**

Table 4.2. Workers on zero-hour job contracts, 2019 - Only employees and self-employed workers (age 16+)

Source: Labour Force Survey 2019 (quarters 2 and 4)

People in non-permanent employment (i.e. those on fixed-term contracts, temporary agency workers and seasonal workers) are also more vulnerable to changing economic conditions such as those generated by the current pandemic. In 2019, EU citizens who had been in the UK for up to five years were less likely to be on a permanent contract compared to other non-UK citizens (about 33,000 said they were in a non-permanent job because they could not find other type of job) (see table A.7 in Annex A).

The share of people in jobs that are considered low or low-medium skilled have earnings that are substantially lower than those of people in higher paid roles, often consider to be high-skilled or professional occupations.[vi] In this context, job skills mainly indicate the educational credentials that are required to perform a job and do not consider other types of personal skills that are valued in the labour market. In 2019, EU citizens who were in the UK for up to five years were overrepresented in so-called "low-skilled" occupations (27 per cent or 200,000) (see Table A.9 in Annex A).

In industries such as retail or hospitality, which have been severely affected by the lockdown during the pandemic, the share of workers in so-called "low" or "medium-low skilled" jobs is very high. EU citizens represent 9 per cent of this low-paid workforce in the retail sector and 14 per cent in the hospitality sector (Table 4.3).

[vi] The classification of jobs as low or low-medium skilled is based on the four-category classification developed by the ONS in 2010.

Industry	Low & medium-low skilled jobs in each industry		Number and shares of non-UK citizens among workers in low & medium-low skilled jobs			
			EU citizens		Non-EU citizens	
	In 1000s	%	In 1000s	%	In 1000s	%
Retail	2,540	63%	230	9%	101	4%
Construction	1,298	23%	80	10%	69	2%
Primary sector	1,223	39%	165	8%	61	1%
Professional & scientific	1,211	22%	47	8%	28	3%
Admin and support services	1,135	57%	154	15%	74	6%
Hospitality	1,114	65%	177	14%	38	7%
Health	875	33%	129	5%	54	4%
Information & communication (incl. IT)	799	13%	52	5%	26	4%
Financial, insurance & real state	782	29%	36	6%	31	3%
Public admin	691	33%	18	3%	12	2%
Social work & residential care	551	64%	54	6%	11	5%
Education	549	36%	41	4%	18	2%
Manufacturing	483	37%	28	16%	17	3%
Transport & storage	347	78%	29	14%	5	5%
Other services & recreational	183	44%	9	7%	8	3%
Total low and medium low-skilled (all sectors)	**13,782**	**43%**	**1,251**	**9%**	**552**	**4%**

Table 4.3. Workers in low-skilled and low-medium skilled jobs by industry, 2019 - Only employees and self-employed (age 16+)

Source: Labour Force Survey 2019

Note: the classification of jobs as low or low-medium skilled is based on the four-category classification developed by the ONS in 2010. In this context, job skills mainly indicate the educational credentials that are required to perform a job and do not consider other types of personal skills that are valued in the labour market.

How many people work in the most affected economic sectors?

The UK government have published a list of business and venues that must remain closed to reduce social contact and slow the spread of infections.[187] As expected, most businesses in the hospitality, accommodation and non-food and non-pharmaceutical retail sectors have been forced to close their premises. About 16 per cent (74,000) of citizens from non-EU countries who migrated to the UK during the last five years work in a business that has been largely or entirely shut down. This share is 25 per cent (183,000) among EU citizens who migrated recently to the UK (Table 4.4).

	Non-EU citizens				EU citizens				UK citizens			
	In the UK for up to 5 years		In the UK for +5 years		In the UK for up to 5 years		In the UK for +5 years		BAME UK citizens		Non-BAME UK citizens	
	In 1000s	%	In 1000s	%	In 1000s	%	In 1000s	%	In 1000s	%	In 1000s	%
Less affected sectors	382	84%	659	77%	538	75%	1,351	82%	2,196	80%	21,848	84%
Non-food, non-pharmaceutical retail	15	3%	36	4%	43	6%	65	4%	140	5%	1,156	4%
Accommodation and food	37	8%	84	10%	92	13%	141	9%	169	6%	1,233	5%
Other affected sectors	22	5%	78	9%	47	7%	98	6%	251	9%	1,887	7%
Total most affected sectors	**74**	**16%**	**198**	**23%**	**183**	**25%**	**303**	**18%**	**560**	**20%**	**4,276**	**16%**
Total	**456**	**100%**	**856**	**100%**	**720**	**100%**	**1,654**	**100%**	**2,756**	**100%**	**26,124**	**100%**

Table 4.4. People working in the most affected economic sectors, 2019 - Only employees and self-employed (age 16+)

Source: Labour Force Survey 2019

Note: List of affected sectors based on IFS Briefing Note BN278 (in 4-digit SIC codes): Non-food, non-pharmaceutical retail (4719, 4730-4772, 4776-4799); passenger transport (4910, 4931-4939, 5010, 5030, 5110); accommodation and food (5510-5630); travel (7911-7990); childcare (8510, 8891); arts and leisure (9001-9329 except 'artistic creation' 9003); personal care (9601-9609 except 'funeral and related activities' 9603); domestic services (9700).[188]
Based on Cabinet Office Guidance on Closing certain businesses and venues, updated on the 9th of April 2020.

People working in the most affected sectors who are on non-permanent contracts or who are self-employed are highly at risk of losing their jobs or experiencing large income losses. Among non-EU citizens with up to five years of residence, there are about 16,000 in this situation, while for EU citizens with up to five years of residence there are about 35,000 (Table 4.5).

	Non-EU citizens				EU citizens				UK citizens			
	In the UK for up to 5 years		In the UK for +5 years		In the UK for up to 5 years		In the UK for +5 years		BAME UK citizens		Non-BAME UK citizens	
	In 1000s	**%**	**In 1000s**	**%**	**In 1000s**	**%**	**In 1000s**	**%**	**In 1000s**	**%**	**In 1000s**	**%**
Less affected sectors	382	84%	659	77%	538	75%	1,351	82%	2,196	80%	21,848	84%
In most affected sectors:												
Permanent	58	13%	139	16%	147	20%	238	14%	365	13%	3,235	12%
Non-permanent	10	2%	8	1%	13	2%	6	0%	38	1%	260	1%
Self-employed	6	1%	50	6%	22	3%	58	4%	153	6%	775	3%
Other employees	0	0%	0	0%	1	0%	1	0%	4	0%	6	0%
Total	**456**	**100%**	**856**	**100%**	**720**	**100%**	**1,654**	**100%**	**2,756**	**100%**	**26,124**	**100%**

Table 4.5. People working in the most affected economic sectors, by type of job contract, 2019
Only employees and self-employed (age 16+)
Source: Labour Force Survey 2019 (all quarters)

Note: List of affected sectors based on IFS Briefing Note BN278 (2020) (in 4-digit SIC codes): Non-food, non-pharmaceutical retail (4719, 4730-4772, 4776-4799); passenger transport (4910, 4931-4939, 5010, 5030, 5110); accommodation and food (5510-5630); travel (7911-7990); childcare (8510, 8891); arts and leisure (9001-9329 except 'artistic creation' 9003); personal care (9601-9609 except 'funeral and related activities' 9603); domestic services (9700).
Based on Cabinet Office Guidance on Closing certain businesses and venues, updated on the 9th of April 2020.

Among people in 'non-essential' occupations, how many are self-employed or on non-permanent contracts?

People in 'non-essential' occupations who are self-employed or on non-permanent contracts are also at risk of losing their jobs or experiencing large income losses, though we cannot estimate the exact shares until the Labour Force Survey data for this quarter is available in July 2020. All those jobs that are excluded from the list of occupations and sectors considered critical to the COVID-19 response published by the Cabinet Office and the Department for Education are considered here as 'non-essential' occupations.[vii] Some of these workers might have not been affected by the pandemic because they can continue performing their jobs remotely from their homes. This is the case, for example, for most workers in administrative or professional occupations. However, other workers in 'non-essential' occupations might have lost their jobs or experience income losses because their jobs can only be done on site (e.g. construction workers, many of whom are also self-employed).

[vii] Note that the list of essential occupations published by the UK includes entire industry sectors and hence, compared to the list provided by the European Commission, a higher share of the working population is defined as essential workers (38 per cent). Other analyses have excluded from the essential occupations list those in local and national government as well as utilities, communications and financial sectors, which we include.

Table 4.6 shows the number of non-UK citizens working in 'non-essential' occupations in 2019 who are on non-permanent contracts or self-employed. Among workers with non-EU citizenship who migrated to the UK during the last five years, 6 per cent (29,000) are on non-permanent contracts and 7 per cent (33,000) are self-employed in non-essential occupations. Among recent EU citizens, the share of workers in 'non-essential' jobs who are on non-permanent contracts (6 per cent or 40,000) or self-employed (12 per cent or 82,000) is even higher.

	Non-EU citizens				EU citizens				UK citizens			
	In the UK for up to 5 years		In the UK for +5 years		In the UK for up to 5 years		In the UK for +5 years		BAME UK citizens		Non-BAME UK citizens	
	In 1000s	**%**	**In 1000s**	**%**	**In 1000s**	**%**	**In 1000s**	**%**	**In 1000s**	**%**	**In 1000s**	**%**
In 'essential jobs'	191	42%	326	38%	209	29%	545	33%	1,191	43%	9,769	37%
In 'non-essential jobs':												
Permanent contract	201	44%	393	46%	387	54%	832	50%	1,157	42%	12,701	49%
Non-permanent contract	29	6%	29	3%	40	6%	39	2%	78	3%	649	3%
Self-employed	33	7%	108	13%	82	12%	236	14%	326	12%	3,013	12%
Total	**455**	**100%**	**856**	**100%**	**719**	**100%**	**1,652**	**100%**	**2,752**	**100%**	**26,132**	**100%**

Table 4.6. Workers in 'non-essential' occupations, by contract type, 2019 - Only employees and self-employed workers (age 16+)

Source: Labour Force Survey 2019

Note: 'Non-essential' occupations are those that are excluded from the list of occupations and sectors considered critical to the COVID-19 response, published by the Cabinet Office and the Department for Education on the 19th of March 2020.[189] This list is quite broad compared to the list provided by the European Commission, and thus a relatively high share of the working population is defined as essential workers (38%).[190]

Our analysis in this section therefore reaffirms that people within the immigration system are at particular risk of experiencing negative socio-economic impacts as a result of COVID-19, due to their occupational profile and employment contract type. In particular, the analysis suggests that recent EU citizens – who in general will not have pre-settled status and so face certain barriers to accessing benefits such as Universal Credit – are highly exposed to the economic consequences of the COVID-19 pandemic, because they are likely to be working in the most affected sectors.

5. The health impact of COVID-19 on people who are non-UK citizens

As with the socioeconomic impacts discussed in Section Four, there are some health impacts associated with COVID-19 that cannot be analysed on the basis of immigration status due to data limitations. In this section, we therefore extend the analysis in the previous section by drawing on survey data to assess some of the potential health risks associated with COVID-19 for non-UK citizens.

Several underlying health conditions have been implicated in increasing the severity of clinical outcomes of COVID-19, as well as morbidity and mortality following infection. These specific health conditions include: pregnancy, BMI >40, cardiovascular disease, diabetes, chronic kidney disease, lung conditions (asthma, COPD, emphysema and/or bronchitis), chronic neurological conditions (Parkinson's disease, motor neurone disease, multiple sclerosis, learning disability or cerebral palsy), splenic disorders (sickle cell disease, spleen removed), chronic liver disease (hepatitis), steroid therapy, HIV/AIDS and immune disorders (chemotherapy). While the evidence-base is still evolving, it is important to highlight where these conditions intersect with health patterns among people in the UK immigration system.

A general review of the evidence suggests that in England and Wales people who are migrants have lower mortality rates compared to the UK-born population. Low all-cause mortality is found in almost all migrant groups, largely as a result of lower mortality from chronic diseases such as cancer.[191] However, identification of people who are migrants in NHS records is difficult, with data on the specific underlying health conditions scarce.

Based on our analysis of self-reported health data from the Annual Population Survey 2019, non-EU and EU citizens are less likely to have a limiting health problem than UK citizens (Table 5.1). (A limiting health problem is a condition that constrains respondents' ability to carry out day-to-day activities.) This is particularly the case among non-UK citizens who moved to the UK in the last five years, who are less likely to report limiting health conditions. For example, among the population aged 35 to 49, 11 per cent of recent non-EU citizens and 9 per cent of recent EU citizens have a limiting health problem, compared to 16 per cent for BAME UK citizens and 20 per cent for white UK citizens. However, this 'health advantage' has been found to decline over time.[192] In addition, for older groups aged between 50 and 64, Table 5.1 suggests that BAME UK citizens are slightly more likely to have limiting health problems than non-BAME UK citizens.

	Age 16 to 34											
	Non-EU citizens				EU citizens				UK citizens			
	In the UK for up to 5 years		In the UK for +5 years		In the UK for up to 5 years		In the UK for +5 years		BAME UK citizens		Non-BAME UK citizens	
	In 1000s	%	In 1000s	%	In 1000s	%	In 1000s	%	In 1000s	%	In 1000s	%
Limiting health problem(s)	30	6%	45	12%	35	6%	69	9%	201	11%	1,979	17%
Total age 16 to 34	**534**	**100%**	**383**	**100%**	**630**	**100%**	**752**	**100%**	**1,789**	**100%**	**11,708**	**100%**
	Age 35 to 49											
	Non-EU citizens				**EU citizens**				**UK citizens**			
	In the UK for up to 5 years		In the UK for +5 years		In the UK for up to 5 years		In the UK for +5 years		BAME UK citizens		Non-BAME UK citizens	
	In 1000s	**%**	**In 1000s**	**%**	**In 1000s**	**%**	**In 1000s**	**%**	**In 1000s**	**%**	**In 1000s**	**%**
Limiting health problem(s)	25	11%	79	14%	22	9%	113	13%	240	16%	1,818	20%
Total age 35 to 49	**237**	**100%**	**569**	**100%**	**234**	**100%**	**892**	**100%**	**1,461**	**100%**	**9,278**	**100%**
	Age 50 to 64											
	Non-EU citizens				**EU citizens**				**UK citizens**			
	In the UK for up to 5 years		In the UK for +5 years		In the UK for up to 5 years		In the UK for +5 years		BAME UK citizens		Non-BAME UK citizens	
	In 1000s	%	In 1000s	%	In 1000s	%	In 1000s	%	In 1000s	%	In 1000s	%
Limiting health problem(s)	9	23%	70	30%	9	17%	94	24%	277	31%	3,038	27%
Total age 50 to 64	**37**	**100%**	**236**	**100%**	**52**	**100%**	**386**	**100%**	**899**	**100%**	**11,082**	**100%**

Table 5.1. Population with a limiting health problem, by age group (self-assessed), 2019
Source: Annual Population Survey 2019

Note: self-assessed health data not asked to under 16s and to all respondents above age 64. A health problem is considering limiting if have lasted or it is expected to last at least 12 months and if it constrains respondents' ability to carry out day-to-day activities.

In general, non-UK citizens have also a lower prevalence of long-lasting mental health problems (see table A.8 in Annex A).

Table 5.2 shows the self-assessed main health problem for the population between the ages of 35 and 64, with conditions notable to COVID-19 highlighted in grey. For nearly every health condition, all non-UK groups have a lower or equal prevalence to UK citizens, including BAME and non-BAME

population. The data in Table 5.2 are not disaggregated by age groups, so some of the observed differences are partially related to the younger age profile of non-UK citizens. It is also important to note that these data are broken down by citizenship and not immigration status. Given the high heterogeneity within the EU and, especially, the non-EU citizen population, health needs vary substantially and may be higher in certain groups, particularly those who are more marginalised, with insecure immigration status or of a lower socioeconomic status. Moreover, it is often these groups who are left without access to health services and who are excluded from national data collection and research.

	Non-EU citizens				EU citizens				UK citizens			
	In the UK for up to 5 years		In the UK for +5 years		In the UK for up to 5 years		In the UK for +5 years		BAME UK citizens		Non-BAME UK citizens	
	In 1000s	**%**	**In 1000s**	**%**	**In 1000s**	**%**	**In 1000s**	**%**	**In 1000s**	**%**	**In 1000s**	**%**
No long-lasting health problem	138	77%	410	69%	150	80%	679	74%	1,221	65%	10,802	60%
limbs	4	2%	23	4%	4	2%	41	5%	104	6%	1,196	7%
cardiovascular	6	3%	29	5%	5	3%	38	4%	105	6%	990	6%
mental	3	2%	18	3%	4	2%	31	3%	64	3%	1,040	6%
back and/or neck	5	3%	24	4%	7	4%	32	4%	81	4%	742	4%
respiratory	2	1%	12	2%	3	2%	10	1%	52	3%	675	4%
diabetes	6	4%	25	4%	3	2%	17	2%	111	6%	486	3%
digestive	3	2%	13	2%	4	2%	13	1%	22	1%	413	2%
progressive (cancer, multiple sclerosis, symptomatic HIV…)	1	0%	8	1%	1	0%	13	1%	29	2%	398	2%
sensory	3	2%	6	1%	1	1%	6	1%	9	1%	187	1%
skin	1	0%	2	0%	1	1%	2	0%	10	1%	97	1%
epilepsy	0	0%	2	0%	0	0%	3	0%	5	0%	93	1%
Other	8	4%	22	4%	5	3%	31	3%	75	4%	934	5%
Total	**179**	**100%**	**592**	**100%**	**186**	**100%**	**915**	**100%**	**1,889**	**100%**	**18,053**	**100%**

Table 5.2 Main health problem, age 35 to 64 (self-assessed), 2019
Source: Labour Force Survey 2019

Note: self-assessed health data not asked to under 16s and to all respondents above age 64. In consequence, the tables below only show data for the population between age 16 and 64. Health conditions included in the table only if lasting or expected to last at least 12 months.

While these tables indicate that generally non-UK citizens are healthy or healthier than UK citizens, the data do not allow us to identify specific groups of the non-UK population, such as people who are asylum seekers or refugees, which tend to have poorer health outcomes, as evidenced in Section Three of this report.

Factors associated with the risk of increased exposure to COVID-19 also include household composition and intergenerational households (see Tables A.10 and A.11 in Annex A). Non-UK citizens of all categories are more likely to live as a couple with some/all dependent children or as 2+ adults from different family units compared with non-BAME UK citizens, suggesting that they tend to live in larger households. Additionally, non-UK citizens have a slightly higher rate of intergenerational households than non-BAME UK citizens, potentially augmenting specific risks for COVID-19 contraction for older household members.

More broadly, as discussed in previous sections, deterrence from healthcare has left a legacy of distrust and fear within certain cohorts of people in the immigration system, leading to a delay in their presentation to healthcare services and potentially worse prognosis of COVID-19. It is essential to examine these existing health conditions and household circumstances within a context of structural inequalities faced by some non-UK populations and how their interplay impacts an individual's risk of worse clinical outcomes from COVID-19.

6. Policy Considerations

Based on our critical appraisal of the existing evidence in this report, we have identified a number of key policy considerations that are relevant for charities working in the migration and refugee sector, for service providers, and for government officials and policy makers. The guiding aim of our policy considerations is to reduce the health and socioeconomic risks of the COVID-19 pandemic and to ensure equitable access to health services for people in the UK's immigration system. We have divided our policy considerations into short, medium and long-term responses.

Short term

Our analysis demonstrates that there are several government policies undermining the national public health response that are particularly inappropriate to continue to enforce in the current context. This includes: policies that prevent certain cohorts of people within the immigration system from accessing secondary NHS care without charge; policies that restrict access to benefits, such as the 'No Recourse to Public Funds' condition and the Habitual Residence Test; immigration enforcement policies that risk facilitating the spread of the virus, such as detention; and policies that deter people from seeking support from public services, such as data-sharing between government departments and the Home Office. While several other countries have suspended many such policies and granted automatic leave to remain for all, in the UK the Home Office's response has so far been confused and ad hoc. There is a clear case for immediately suspending or reviewing these harmful policies in light of the COVID-19 pandemic and for granting an automatic extension for all visa holders.

It must be acknowledged that the fear generated through the hostile environment and the perception of lack of entitlement is not bound up solely in its policies, but also through years of publicity and a general culture shift in public services that prioritises questions of entitlement over service provision. Thus, any policy suspension will only be effective if accompanied by widespread linguistically and culturally accessible information campaigns, targeting the public, people within the immigration system, and the staff that work in the services concerned.

There is also an urgent need to address the culture and practice within primary care services that excludes many cohorts within the immigration system and perpetuates poor knowledge and confusion over how to navigate the NHS. NHS England should put out emergency communications to all GP practices reminding them of their obligation to register all patients in their catchment area, including those without a fixed address and regardless of immigration status.

Our analysis also suggests that numerous grassroots and local community services are struggling to stay operational due to the impact of the COVID-19 pandemic on their services, finances, and staff, with some at risk of collapse. This further severely restricts essential avenues of support for marginalised cohorts of people within the immigration system, particularly those that face digital access barriers and so cannot engage with equivalent support virtually. There is an urgent need for action to ensure that these services are assisted and properly resourced to continue their operations, and that nationally coordinated aid efforts account for the needs of people in the immigration system.

Medium term

Our analysis highlights specific mental health needs among several cohorts of people within the immigration system – which could be severely exacerbated by the current crisis and its subsequent socioeconomic impact. There is a need for targeted investment and support for mental health and related services, particularly once restrictions on movement are relaxed, and face-to-face support can begin to be reinstated.

Our research also suggests that some cohorts are concentrated in specific 'key worker' sectors of the labour market, as well as in sectors that are disproportionately affected by restrictions in movement and activities due to the COVID-19 pandemic. As the lockdown begins to lift, it is critical to monitor how the changing labour market affects people within the immigration system and to guard against the risk of a rise in exploitative working conditions in response to higher levels of unemployment.

Based on our analysis, we have also identified that there is a risk that some people could be forced into overstaying their current visa and/or losing their immigration status due to the COVID-19 pandemic and the inflexibility of current immigration rules. This should be monitored closely and addressed through appropriate adjustments and concessions in order to avoid unjust penalisation of people affected by immigration control.

Long term

The current crisis has highlighted major failings in protecting the health of people in the immigration system and in ensuring resilience to public health emergencies. To prevent such events disproportionately impacting people within the immigration system in the future, it is critical for the UK to implement a more inclusive and equitable approach to health policies and access to healthcare.

Immigration and public service policies should recognise the interconnections between health, race, ethnicity, gender, and immigration status. In their future planning for public health emergencies, policymakers should consider the potential barriers to following public health advice, the impacts of immigration policies affecting access to benefits and public services, and the importance of specialist healthcare support and training.

Over the long term, our analysis suggests that a new strategy is needed to address the structural policy failings that have impeded the public health response to this crisis. This strategy should ensure that Home Office policy supports the UK's broader public health objectives and that the government protects and promotes the physical and mental health of all people, regardless of their immigration status.

Annex A: Additional data tables for Sections Four and Five

	UK citizens			
	White		Black, Asian and minority ethnic	
	In 1000s	**%**	**In 1000s**	**%**
UK born	51,317	98%	4,503	65%
EU born	529	1%	39	1%
Non-EU born	746	1%	2,395	35%
Total	**52,592**	**100%**	**6,937**	**100%**

Table A.1. Place of birth of white and BAME population among UK citizens, 2019
Source: Annual Population Survey 2019

	UK born		**Foreign born In the UK for up to 5 years**		**Foreign born In the UK for +5 years**		**Total**	
	In 1000s	**%**	**In 1000s**	**%**	**In 1000s**	**%**	**In 1000s**	**%**
UK citizen	55,837	99%	168	7%	3,505	49%	59,511	90%
EU citizen	523	1%	1,118	49%	2,240	32%	3,881	6%
EU-14	302	1%	513	22%	1,050	15%	1,865	3%
EU-8, EU-2, EU Other	221	0%	605	26%	1,190	17%	2,016	3%
Non-EU citizen	137	0%	1,013	44%	1,344	19%	2,495	4%
MENA & Central Asia	16	0%	160	7%	103	2%	279	0%
East & Southeast Asia	17	0%	159	7%	161	2%	337	1%
India	32	0%	205	9%	255	4%	493	1%
Pakistan & other South Asia	14	0%	66	3%	148	2%	228	0%
Sub-Saharan Africa	28	0%	123	5%	293	4%	444	1%
Other countries	30	0%	300	13%	384	5%	714	1%
Total	**56,497**	**100%**	**2,300**	**100%**	**7,090**	**100%**	**65,887**	**100%**

Table A.2. Citizenship by time spent in the UK (all ages), 2019
Source: Annual Population Survey 2019

	Non-EU citizens				EU citizens				UK citizens			
	In the for up to 5 years		In the UK for +5 years		In the for up to 5 years		In the UK for +5 years		BAME UK citizens		Non-BAME UK citizens	
	In 1000s	%	In 1000s	%	In 1000s	%	In 1000s	%	In 1000s	%	In 1000s	%
Under 18	208	21%	183	12%	210	19%	535	19%	2,597	37%	10,355	20%
Age 18-34	518	51%	366	25%	613	55%	704	26%	1,584	23%	10,672	20%
Age 35-49	238	24%	572	39%	234	21%	896	32%	1,466	21%	9,297	18%
Age 50-64	37	4%	237	16%	52	5%	387	14%	901	13%	11,110	21%
Over 64	13	1%	122	8%	9	1%	243	9%	413	6%	11,160	21%
Total	**1,014**	**100%**	**1,481**	**100%**	**1,118**	**100%**	**2,764**	**100%**	**6,960**	**100%**	**52,595**	**100%**

Table A.3. Age distribution of the non-UK citizen population, by years since migration (up to five years in the UK vs more than five years), 2019

Source: Annual Population Survey 2019

	Men											
	Non-EU citizens				EU citizens				UK citizens			
	In the UK for up to 5 years		In the UK for +5 years		In the UK for up to 5 years		In the UK for +5 years		BAME UK citizens		Non-BAME UK citizens	
	In 1000s	%	In 1000s	%	In 1000s	%	In 1000s	%	In 1000s	%	In 1000s	%
Employee & GES	223	59%	351	58%	348	74%	662	62%	1,187	53%	11,002	52%
Self-employed	32	9%	103	17%	74	16%	195	18%	352	16%	2,543	12%
Unemployed	22	6%	26	4%	12	3%	24	2%	102	5%	541	3%
Student	64	17%	27	5%	24	5%	52	5%	244	11%	770	4%
Inactive (except students)	35	9%	94	16%	13	3%	141	13%	338	15%	6,403	30%
Total	**377**	**100%**	**603**	**100%**	**471**	**100%**	**1,075**	**100%**	**2,227**	**100%**	**21,309**	**100%**
	Women											
	Non-EU citizens				**EU citizens**				**UK citizens**			
	In the UK for up to 5 years		In the UK for +5 years		In the UK for up to 5 years		In the UK for +5 years		BAME UK citizens		Non-BAME UK citizens	
	In 1000s	%	In 1000s	%	In 1000s	%	In 1000s	%	In 1000s	%	In 1000s	%
Employee & GES	173	39%	352	49%	307	67%	735	61%	1,209	51%	10,880	50%
Self-employed	15	3%	56	8%	28	6%	108	9%	130	6%	1,328	6%
Unemployed	26	6%	26	4%	21	5%	31	3%	84	4%	393	2%
Student	72	16%	37	5%	31	7%	45	4%	238	10%	741	3%
Inactive (except students)	159	36%	241	34%	69	15%	285	24%	688	29%	8,602	39%
Total	**446**	**100%**	**713**	**100%**	**455**	**100%**	**1,206**	**100%**	**2,352**	**100%**	**22,001**	**100%**

Table A.4. Main economic activity of men and women (age 16+), 2019

Source: Annual Population Survey 2019

Note: unpaid family workers not shown in the table, but they are included in the row total. The inactive population includes full-time students, retirees, and those who are looking after their families. GES refers to workers in Government Employment Schemes.

	Non-EU citizens				EU citizens				UK citizens			
	In the UK for up to 5 years		In the UK for +5 years		In the UK for up to 5 years		In the UK for +5 years		BAME UK citizens		Non-BAME UK citizens	
	In 1000s	**%**	**In 1000s**	**%**	**In 1000s**	**%**	**In 1000s**	**%**	**In 1000s**	**%**	**In 1000s**	**%**
Employee & GES	42	24%	35	35%	127	61%	99	44%	333	36%	2,882	55%
Self-employed	5	3%	2	2%	12	6%	6	3%	16	2%	159	3%
Unemployed	10	6%	8	8%	14	7%	13	6%	84	9%	348	7%
Student	90	53%	43	42%	46	22%	88	39%	441	47%	1,388	26%
Inactive (except students)	24	14%	12	12%	10	5%	18	8%	62	7%	467	9%
Total	**171**	**100%**	**101**	**100%**	**209**	**100%**	**226**	**100%**	**936**	**100%**	**5,253**	**100%**

Table A.5. Main economic activity of the population (age 16 to 24), 2019
Source: Annual Population Survey 2019

Note: unpaid family workers not shown in the table, but they are included in the row total. The inactive population includes full-time students, retirees, and those who are looking after their families.

	Non-EU citizens				EU citizens				UK citizens			
	In the UK for up to 5 years		In the UK for +5 years		In the UK for up to 5 years		In the UK for +5 years		BAME UK citizens		Non-BAME UK citizens	
	In 1000s	**%**	**In 1000s**	**%**	**In 1000s**	**%**	**In 1000s**	**%**	**In 1000s**	**%**	**In 1000s**	**%**
All active members employed	745	72%	1,171	80%	952	88%	2,254	85%	5,337	79%	38,002	72%
Some active members unemployed	70	7%	61	4%	70	7%	115	4%	433	6%	1,671	3%
All active members unemployed	41	4%	43	3%	17	2%	25	1%	163	2%	708	1%
Inactive household	181	18%	198	13%	38	4%	261	10%	820	12%	12,566	24%
Total	**1,037**	**100%**	**1,472**	**100%**	**1,078**	**100%**	**2,656**	**100%**	**6,754**	**100%**	**52,946**	**100%**

Table A.6. Population living in a household where all their active household members are unemployed (all ages), 2019
Source: Labour Force Survey 2019

Note: active population refers to people who are in employment (employees, self-employed or in government training programmes) or unemployed. The inactive population includes children under age 16, full-time students, retirees, and those who are looking after their families.
families.

	Non-EU citizens				EU citizens				UK citizens			
	In the UK for up to 5 years		In the UK for +5 years		In the UK for up to 5 years		In the UK for +5 years		BAME UK citizens		Non-BAME UK citizens	
	In 1000s	**%**	**In 1000s**	**%**	**In 1000s**	**%**	**In 1000s**	**%**	**In 1000s**	**%**	**In 1000s**	**%**
Permanent job	349	89%	655	93%	584	90%	1,324	95%	2,224	93%	20,786	95%
Temporary job- couldn't find permanent	13	3%	19	3%	33	5%	24	2%	40	2%	230	1%
Temporary job- other reasons	32	8%	28	4%	34	5%	46	3%	119	5%	809	4%
Total	**394**	**100%**	**702**	**100%**	**651**	**100%**	**1,394**	**100%**	**2,383**	**100%**	**21,825**	**100%**

Table A.7. Workers on permanent and non-permanent contracts, 2019
Only employees (age 16+)
Source: Annual Population Survey 2019

	Non-EU citizens				EU citizens				UK citizens			
	In the UK for up to 5 years		In the UK for +5 years		In the UK for up to 5 years		In the UK for +5 years		BAME UK citizens		Non-BAME UK citizens	
	In 1000s	**%**	**In 1000s**	**%**	**In 1000s**	**%**	**In 1000s**	**%**	**In 1000s**	**%**	**In 1000s**	**%**
Physical condition	87	11%	202	17%	81	9%	289	15%	796	20%	7,312	23%
Mental health condition	12	1%	30	3%	10	1%	41	2%	101	3%	1,442	4%
Physical & mental health conditions	11	1%	43	4%	8	1%	56	3%	150	4%	2,203	7%
Total	**817**	**100%**	**1,168**	**100%**	**886**	**100%**	**1,969**	**100%**	**4,022**	**100%**	**32,418**	**100%**

Table A.8. Population with a health condition (both limiting and non-limiting), age 16 to 64 (self-assessed), 2019
Source: Labour Force Survey 2019

Note: self-assessed health data not asked to under 16s and to all respondents above age 64. In consequence, the tables below only show data for the population between age 16 and 64. Health conditions included in the table only if lasting or expected to last at least 12 months.

	Non-EU citizens				EU citizens				UK citizens			
	In the UK for up to 5 years		In the UK for +5 years		In the UK for up to 5 years		In the UK for +5 years		BAME UK citizens		Non-BAME UK citizens	
	In 1000s	**%**	**In 1000s**	**%**	**In 1000s**	**%**	**In 1000s**	**%**	**In 1000s**	**%**	**In 1000s**	**%**
Low-skilled jobs	66	15%	117	14%	200	27%	276	16%	278	10%	2,382	9%
Medium-low skilled	103	23%	276	32%	236	31%	562	33%	989	35%	8,268	32%
Total at all skill levels	**496**	**100%**	**924**	**100%**	**854**	**100%**	**1,571**	**100%**	**2,948**	**100%**	**27,513**	**100%**
Numbers and shares in top 5 low-skilled jobs												
Other Elementary Services Occupations	17	2%	35	3%	53	5%	63	6%	93	9%	793	75%
Elementary Cleaning Occupations	16	2%	34	5%	36	5%	94	13%	43	6%	492	69%
Elementary Storage Occupations	11	3%	11	2%	42	9%	52	12%	33	7%	300	67%
Elementary Security Occupations	7	2%	12	4%	2	1%	13	4%	50	15%	241	74%
Elementary Process Plant Occupations	8	3%	10	4%	26	11%	40	17%	17	7%	138	58%
Numbers and shares in top 5 medium-low skilled jobs												
Caring Personal Services	17	1%	63	5%	20	2%	63	5%	153	11%	1,051	77%
Sales Assistants and Retail Cashiers	13	15	39	3%	20	2%	51	4%	134	10%	1,090	81%
Road Transport Drivers	10	1%	37	4%	45	5%	68	7%	131	14%	669	70%
Childcare and Related Personal Services	4	1%	13	2%	8	1%	28	3%	74	9%	713	85%
Other Administrative Occupations	11	1%	14	2%	10	1%	28	3%	57	7%	710	86%

Table A.9. Workers in low-skilled and low-medium skilled jobs, 2019 - Only employees and self-employed (age 16+)

Source: Labour Force Survey 2019 and Annual Population Survey 2019

Note: the classification of jobs as low or low-medium skilled is based on the four-category classification developed by the ONS in 2010. In this context, skills mostly indicate the educational level and training required in an occupation and do not measure other types of skills that are valued in the labour market (e.g. soft skills).

	Non-EU citizens				EU citizens				UK citizens			
	In the UK for up to 5 years		In the UK for +5 years		In the UK for up to 5 years		In the UK for +5 years		BAME UK citizens		Non-BAME UK citizens	
	In 1000s	**%**	**In 1000s**	**%**	**In 1000s**	**%**	**In 1000s**	**%**	**In 1000s**	**%**	**In 1000s**	**%**
Couple + some/all dependent children	507	49%	680	46%	362	34%	1,208	46%	3,135	46%	17,625	33%
Couple without offspring in household	177	17%	218	15%	235	22%	458	17%	525	8%	13,891	26%
Single-parent + dependent children	35	3%	128	9%	72	7%	187	7%	972	14%	3,786	7%
Couple + non-dependent children	21	2%	80	5%	19	2%	147	6%	429	6%	4,479	9%
1 adult below pensionable age	75	7%	92	6%	73	7%	160	6%	357	5%	3,748	7%
1 adult 65+, no children	1	0%	36	3%	2	0%	79	3%	115	2%	3,732	7%
Single-parent + non- dependent children	2	0%	37	3%	11	1%	45	2%	273	4%	1,778	3%
Other household types with non-dependent children or no children	45	4%	60	4%	88	8%	113	4%	255	4%	1,476	3%
2+ adults, all different family units	98	9%	36	2%	114	11%	88	3%	131	2%	1,132	2%
Other household types with some/all dependent children	42	4%	54	4%	51	5%	86	3%	347	5%	787	2%
Couple + some/all dependent children + other family units	34	3%	50	3%	50	5%	85	3%	214	3%	507	1%
Total	**1,037**	**100%**	**1,472**	**100%**	**1,077**	**100%**	**2,655**	**100%**	**6,753**	**100%**	**52,942**	**100%**

Table A.10. Population living in different types of households, 2019

Source: Labour Force Survey 2019

Note: a family unit is a married, civil partnered or cohabiting couple with or without children, or a lone parent with at least one child, who lives at the same address. Children may be dependent or non-dependent.

Dependent children are those living with their parent(s) who are either under age 16 or aged 16 to 18 and in full-time education. Non-dependent children (or adult children) are thus those living with their parents who are aged 19 or over, or aged 16-18 and not in full-time education and have no spouse, partner or child living in the household.

	Non-EU citizens				EU citizens				UK citizens			
	In the for up to 5 years		In the UK for +5 years		In the for up to 5 years		In the UK for +5 years		BAME UK citizens		Non-BAME UK citizens	
	In 1000s	**%**	**In 1000s**	**%**	**In 1000s**	**%**	**In 1000s**	**%**	**In 1000s**	**%**	**In 1000s**	**%**
Living in Intergenerational households	19	2%	40	3%	16	2%	39	2%	269	4%	540	1%
Total	**1,037**	**100%**	**1,472**	**100%**	**1,078**	**100%**	**2,656**	**100%**	**6,754**	**100%**	**52,946**	**100%**

Table A.11. Population living in Intergenerational households, 2019

Source: Labour Force Survey 2019

Note: Intergenerational households are those with at least a member aged 64+ and a member below age 18.

Annex B: Limitations

Routine national surveys and statistics often miss some of the more marginalised and hard-to-reach cohorts in the UK immigration system. For example, data on those under 16 years old and those not living in a private household will not be included in data collection and thus excluded from national surveys. As a result, the health needs and relevant socioeconomic determinants of health of some people within the immigration system will not be represented in the data.

Additionally, as much existing research and data does not disaggregate by immigration status and instead defines people by nationality or country of birth, there were some gaps in our analysis where no specific evidence could be identified. These areas have been identified throughout the report.

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