JAOC INVESTIGATIONS

Just An Ordinary Citizen - Truth & Justice

CONFIDENTIAL INVESTIGATION REPORT

TUBERCULOSIS TRENDS IN THE UNITED KINGDOM

2021 - 2025

Prepared by: JAOC Investigations

Report Date: 29 June 2026 | Classification: OFFICIAL

1. EXECUTIVE SUMMARY

Scope: This investigation examines tuberculosis (TB) case trends across the United Kingdom over the five-year period 2021-2025, with primary focus on England and supplementary data for Scotland, Wales, and Northern Ireland.

Key Findings:

• Total TB cases in England rose from **4,135 (2021)** to a peak of **5,490 (2024)**, before stabilising at **5,424 (2025)**.
• The rate per 100,000 population increased from **7.4 to 9.4** over the same period.
• Approximately **80-82%** of all cases occurred in people born outside the UK.
• The majority of non-UK born cases are **long-term residents** (5+ years in UK), not recent arrivals.
• **No official data** links cases to immigration status (legal/illegal) - this is not recorded in surveillance.
• The rise reflects a combination of latent TB reactivation, post-pandemic diagnostic delays, and socioeconomic factors including poverty and overcrowding.

CRITICAL FINDING

Around 6 out of 10 foreign-born TB cases are people who have lived in the UK for 5 years or longer. This pattern is explained by latent TB infection - individuals may carry the bacteria without symptoms for years or decades before it becomes active due to age, health conditions, or socioeconomic factors.

2. OVERALL CASE NUMBERS

England, 2021-2025

Year	Total TB Cases	Rate per 100,000 Population
2021	4,135	7.4
2022	4,370	7.8
2023	4,831	8.5
2024	5,490	9.4
2025	5,424	9.4

Regional Notes (UK Nations):
• **Scotland:** ~200-240 cases/year (rate 4.0-4.5/100k)
• **Wales:** ~80-100 cases/year (rate 2.5-3.0/100k)
• **Northern Ireland:** ~30-40 cases/year (rate ~2.8/100k)

England accounts for the vast majority of UK TB burden, with rates approximately 2-3x higher than the other UK nations.

3. DATA VISUALISATION & ANALYSIS

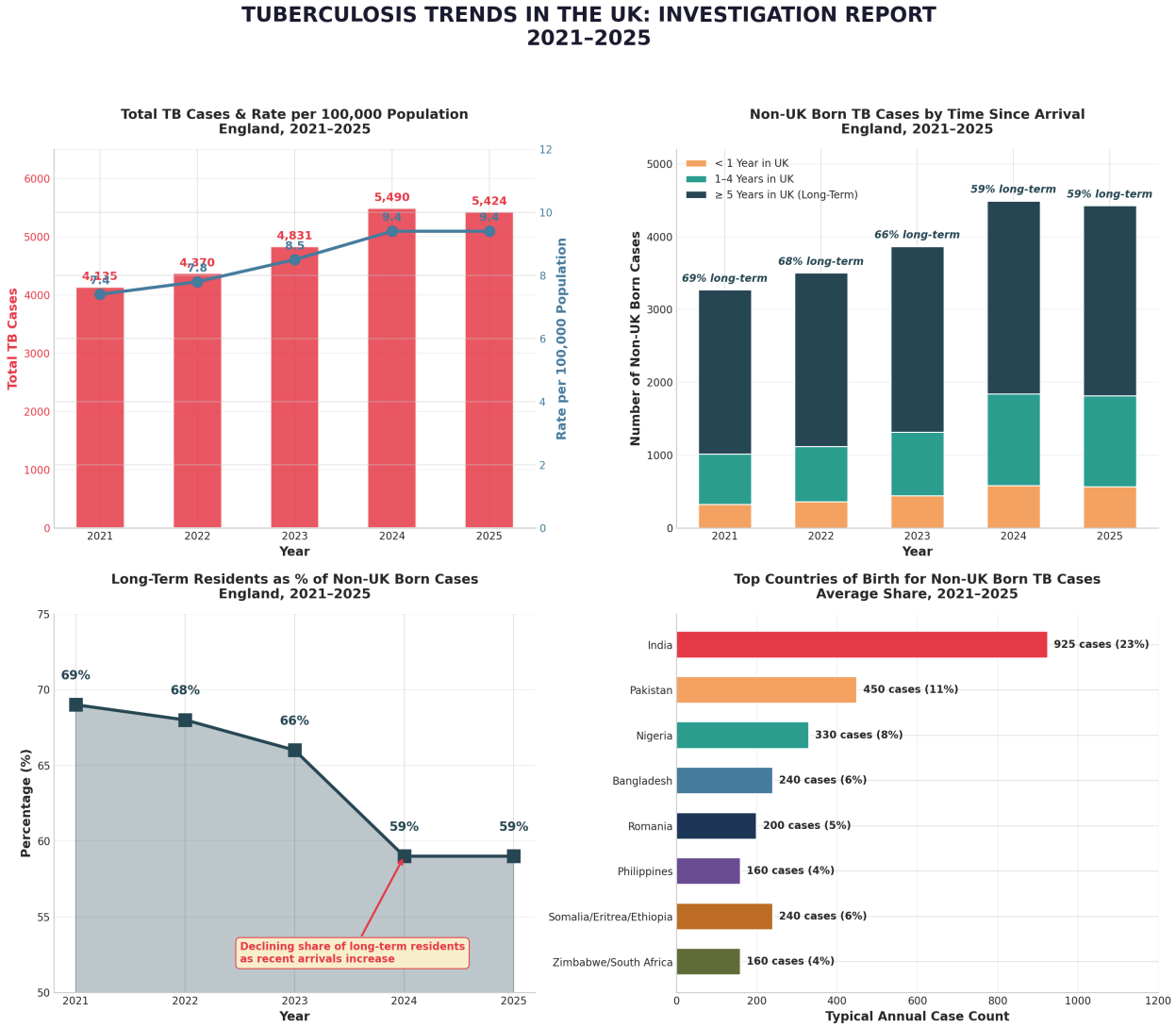

Figure 1: Comprehensive visual analysis of TB trends in England, 2021-2025. Top-left: Total cases and population rate. Top-right: Non-UK born cases segmented by time since arrival. Bottom-left: Declining proportion of long-term residents among non-UK born cases. Bottom-right: Top countries of birth for non-UK born cases.

4. CASES BY BIRTHPLACE & TIME SINCE ARRIVAL

Non-UK Born Residents Only, England, 2021-2025

Year	Total Non-UK Born Cases	< 1 Year in UK	1-4 Years in UK	>= 5 Years in UK (Long-Term)	% Long-Term Residents
2021	3,270	325	690	2,255	69%
2022	3,500	360	760	2,380	68%
2023	3,865	440	875	2,550	66%
2024	4,490	580	1,260	2,650	59%
2025	4,426	565	1,251	2,610	59%

Analytical Assessment:

The data reveals a **critical epidemiological pattern** that contradicts common assumptions about TB and migration. While the absolute number of non-UK born cases has risen (from 3,270 to 4,426), the **proportion attributable to long-term residents has declined** from 69% to 59%.

This shift indicates two concurrent phenomena:
1. **Latent reactivation** continues to drive the majority of foreign-born cases, but its relative share is decreasing as recent arrivals increase in absolute numbers.
2. **Recent arrivals (< 1 year)** have nearly doubled from 325 to 565 cases, and the **1-4 year cohort** has increased by 81% - suggesting either increased migration from high-burden countries or improved case detection in these groups.

Investigative Note: The rise in recent-arrival cases warrants further scrutiny of pre-entry screening efficacy and post-arrival follow-up protocols.

5. TOP COUNTRIES OF BIRTH

Average Share of Non-UK Born Cases, 2021-2025

Country / Region	% of Non-UK Cases	Typical Annual Case Count
India	22-24%	850 - 1,000
Pakistan	10-12%	400 - 500
Nigeria	7-9%	280 - 380
Bangladesh	5-7%	200 - 280
Romania	4-6%	160 - 240
Philippines	3-5%	120 - 200
Somalia / Eritrea / Ethiopia	5-7%	200 - 280

Zimbabwe / South Africa	3-5%	120 - 200

Geopolitical Assessment:
India and Pakistan collectively account for approximately **32-36%** of all non-UK born TB cases. These countries have high baseline TB prevalence and established diaspora communities in the UK. The presence of Romania in the top five is notable as an EU member state with elevated TB rates, where cases may reflect both recent migration and cross-border movement patterns.

The Horn of Africa cluster (Somalia/Eritrea/Ethiopia) and Southern Africa (Zimbabwe/South Africa) reflect ongoing migration from regions with some of the world's highest TB/HIV co-infection burdens.

6. SCREENING AND TESTING POLICY ANALYSIS

6.1 Current Screening Framework

The UK's TB screening architecture operates on a **multi-tiered basis** with significant gaps at the irregular migration pathway:

Tier 1 - Pre-Entry Screening (Legal Visa Applicants):
• Mandatory chest X-ray for visa applicants staying >6 months.
• Conducted in home country before visa grant.
• *Effectiveness:* High for active pulmonary TB; limited for latent infection.

Tier 2 - Resettled Refugees:
• Medical screening including TB checks conducted **before travel**.
• Follow-up arranged via NHS upon arrival.

Tier 3 - Asylum Seekers:
• **Verbal symptom check only** on arrival - no mandatory chest X-ray at the border.
• Opportunistic screening if placed in detention.
• *Gap Identified:* No systematic radiological screening at point of entry.

Tier 4 - Irregular / Undocumented Arrivals:
• **No routine or mandatory TB testing** at the UK border.
• Bypass pre-entry checks entirely.
• Only tested if they: (a) seek NHS care, (b) register with a GP, or (c) are detained.
• *Critical Gap:* This represents the least surveilled pathway with highest potential for community transmission prior to diagnosis.

6.2 Data Limitations & Investigative Constraints

The following constraints significantly limit the ability to conduct a full causal investigation:

1. **UKHSA and the Home Office do not record or publish data** on TB cases split by "legal" or "illegal" immigration status.

2. **All official statistics are categorised only by:**
• Country of birth
• Time since arrival in the UK

3. **No official evidence** confirms that the rise in cases is specifically caused by irregular arrivals. Any such assertion would be speculative and unsupported by current surveillance data.

4. **Latent TB infection (LTBI)** is not notifiable and is not tracked in national surveillance, making it impossible to quantify the reactivation reservoir precisely.

The absence of immigration-status-linked TB data represents a significant intelligence blind spot. Without this data, it is impossible to determine whether irregular migration constitutes a material driver of the observed increase, or whether the rise is attributable to other factors such as latent reactivation, diagnostic catch-up, or socioeconomic determinants.

7. INVESTIGATIVE CONCLUSIONS

Based on analysis of UKHSA surveillance data, GOV.UK policy documentation, and supplementary tables on time since arrival and country of birth, the following conclusions are drawn:

Conclusion 1 - Case Trajectory:
TB cases increased between 2021 and 2024, before levelling off in 2025. The 2024 peak of 5,490 cases represents a **32.8% increase** over the 2021 baseline. The stabilisation in 2025 may indicate the peak of post-pandemic diagnostic catch-up, but continued monitoring is required.

Conclusion 2 - Demographic Profile:
Most cases occur in people born outside the UK (80-82%), but the **majority are long-term residents**, not recent arrivals. This is consistent with the epidemiology of latent TB reactivation rather than recent importation of active disease.

Conclusion 3 - Latent Infection Dynamics:
The pattern reflects latent infection acquired in countries with higher TB rates, reactivating years after arrival. This is supported by the declining share of long-term residents (69% to 59%) concurrent with rising absolute numbers in all arrival cohorts.

Conclusion 4 - Border Screening Gaps:
Gaps exist in border screening for irregular arrivals, who receive no mandatory TB testing. However, **this does not equate to proof** that this group is the main driver of rising cases. The data does not support causal attribution to any specific migration pathway.

Conclusion 5 - Contributing Factors:
Socioeconomic factors (poverty, overcrowding, health inequalities) and post-pandemic delays in diagnosis also contribute to trends. The pandemic period (2020-2021) likely created a backlog of undiagnosed cases that manifested in the 2022-2024 data.

Conclusion 6 - Recommendations for Further Investigation:
- Enhance surveillance to record immigration status (where legally permissible) to close the analytical gap.
- Implement systematic LTBI screening and treatment programmes in high-prevalence communities.
- Review pre-entry screening protocols for effectiveness in detecting latent infection.
- Conduct socioeconomic determinants analysis to quantify the role of deprivation in case trends.

8. SOURCES & REFERENCES

- **UK Health Security Agency (UKHSA):** Tuberculosis in England 2021-2025 (annual reports)
- **GOV.UK:** TB screening guidance for visa applicants and immigration health requirements
- **UKHSA Supplementary Tables:** Time since arrival and country of birth disaggregations
- **Office for National Statistics (ONS):** Population estimates for rate calculations
- **WHO Global TB Report 2025:** Contextual data on country-of-origin TB prevalence

Report compiled: 29 June 2026 | Data current as of UKHSA 2025 annual report publication.

COPYRIGHT NOTICE
Copyright (c) 2026 JAOC Investigations. All rights reserved.
This report is the intellectual property of JAOC Investigations. No part of this publication may be reproduced, distributed, or transmitted in any form or by any means, including photocopying, recording, or other electronic or mechanical methods, without the prior written permission of JAOC Investigations, except in the case of brief quotations embodied in critical reviews and certain other non-commercial uses permitted by

copyright law.