
PATIENTS NOT PASSPORTS:

Migrants' Access to Healthcare During the Coronavirus Crisis

June 2020

Medact, Migrants Organise, New Economics Foundation

ABOUT

Patients Not Passports



The Patients Not Passports campaign aims to end the Government's Hostile Environment in the NHS, by organising with healthcare workers, migrant and community organisations and groups, and concerned citizens, to oppose immigration enforcement in public services. The campaign was founded by Docs Not Cops, and has grown to include Medact, Migrants Organise and the New Economics Foundation. Through the campaign, we support people to advocate for those facing charges for NHS care, and to take action to end immigration checks and charging in the NHS.

Medact



Medact is a public health charity that works to mobilise the health community in the UK to effect progressive social change. We primarily conduct research and analysis of different social issues, use this research to inform and educate health professionals and the wider public, and lobby and campaign for change. We work with a membership base of thousands of healthcare workers, public health professionals, and global health academics.

Migrants Organise



Migrants Organise provides a platform for refugees and migrants to organise for power, dignity and justice. Our mission is to enable their meaningful inclusion and integration. We believe migration is a fact of life and that instead of resisting it, we must organise it. Migrants Organise was established in 1993 by 14 migrant and refugee leaders in West London. We work with migrant and refugee communities to build their capacity to connect, participate and establish common ground.

The New Economics Foundation



For more than three decades, the New Economics Foundation's mission has been to transform the economy so it works for people and the planet. We work with people igniting change from below and combine this with rigorous research to fight for change at the top.

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EXECUTIVE SUMMARY

The rapid emergence and development of Covid-19 has thrown the world into a crisis, the likes of which has not been seen in our lifetimes. The crisis has laid bare the UK's structural inequalities and injustices. One of the most prominent is the disproportionately high number of migrant and BAME deaths due to the virus. Black people are four times more likely to die than white people, and Bangladeshi or Pakistani groups are three times more likely.

Our research presents new evidence of the inequalities faced by BAME and migrant communities. We demonstrate how the Government's Hostile Environment immigration policies, along with other barriers, exacerbate these inequalities; and the role they play in preventing migrant and BAME people from accessing healthcare. We have identified urgently needed changes of policy and practice to help prevent deaths and suffering in these communities, which we have outlined below.

In mid-April, an undocumented Filipino migrant known as Elvis died at home with suspected coronavirus. He had lived and worked in the UK with his wife for more than 10 years, but was so scared by the hostility of Government policies that he did not seek any help from the NHS. He had suffered symptoms for two weeks. His death demonstrates that barriers to accessing healthcare for migrants have become exponentially more damaging during the pandemic.

The devastating consequences of the virus in these communities can only be curtailed if governments respond with inclusive measures designed to protect everyone's right to life and to health. This must include all migrants, many of whom are disproportionately at risk of exclusion, stigma and discrimination, particularly when undocumented.

Medact, Migrants Organise, and the New Economics Foundation have undertaken crucial research to understand and raise awareness of barriers to healthcare for migrants during the coronavirus crisis, and to help inform the response to this emergency. We surveyed migrant and refugee support organisations and community groups from across the UK. We then undertook interviews with a subsection of respondents in order to gather further information.

Our research shows that:

- **Migrants are not coming forward for healthcare because of the Government's Hostile Environment.**

It has long been common for migrants to avoid seeking healthcare because of these policies, which include NHS charging and data sharing with the Home Office. Tragically, this remains the case during the pandemic. 57% of respondents in our research report that migrants have avoided seeking healthcare because of fears of being charged for NHS care, data sharing and other migration enforcement concerns. Due to the complex nature of the policies, and the lack of staff and patient knowledge about eligibility, even those entitled to free care under the current policy are deterred from seeking healthcare.

- **The coronavirus exemption from charging is not working**

While treatment for coronavirus and other communicable diseases is exempt from charging, few respondents (20%) agree that migrants are aware of this exemption. Most of those responding to the survey (56%) have not seen any information from public bodies raising awareness of migrants' rights to healthcare during the coronavirus crisis. Fewer still (9%) think that information about charging exemptions is reaching all sections of their communities in an accessible format. Further, there are reported instances of people being required to prove their entitlement to care whilst in hospital with coronavirus symptoms.

Even when this information gets through, a decade of Hostile Environment policies means that fear and mistrust prevail, and the deterrent effect persists. This is compounded by fears of data sharing and immigration enforcement, as the Department of Health and Social Care has made no assurances that patient data will not be shared with the Home Office.

- **Migrants face a wide range of additional barriers – including language and digital exclusions – to accessing care, including emergency services.**

For those that come forward despite the fear created by the Hostile Environment, the coronavirus crisis has created additional barriers to accessing care. As many services - including health services and migrant support services - shut and others move online, the crisis has also shed new light on existing barriers, which are exacerbated and compounded during the pandemic. Chief amongst the additional barriers to care are: the absence of translation and interpretation services; digital exclusions; housing and proximity to care services. Further, a fear of contracting coronavirus while accessing healthcare, leading to an avoidance of services, has been exacerbated by fears of discriminatory treatment and the disproportionate number of migrant and BAME coronavirus death.

Our research shows that migrants face many barriers to accessing healthcare, and provides an important insight into the daily experiences of migrants living under the Hostile Environment. The health system overlooks the specific needs of migrants and the fear and deterrence they face. These delays in seeking care result in harrowing examples of harm and needless death.

It is important to note that many migrants, especially those whose status is most precarious, often do not receive any support from migrant organisations. The results of this research, therefore, are likely to understate the scale and depth of the issues highlighted.

What needs to change

The findings of this research demonstrate that current exemptions, as well as the Government's emergency pandemic policies, are not working. We conclude, in line with recommendations set out by the Lancet Commission on Migration and Health as well as many others, that the only way to address these failures is to end the Hostile Environment in the NHS altogether. This entails:

1. **Withdrawing all NHS charging for migrants**, in particular the National Health Service Overseas Visitor Charging Regulations 2015 and 2017 and the Immigration Health Surcharge.
2. **Ending all data sharing** between the NHS and other health services, and the Home Office. The government should implement a firewall to ensure that patient data will never be shared with the Home Office or other bodies for the purposes of immigration enforcement.
3. **Launching an information campaign** to ensure both NHS staff and the public are aware of these changes and that it is safe for people to seek care. It should be done with a particular focus on migrant communities across the UK with the intention of undoing the deterrent effects of the Hostile Environment. It should also inform people about their right to access translation services and translated guidance throughout their engagement with the NHS, and impress upon NHS Trusts their requirement to meet this need.

These measures are urgently needed. They echo the recommendations made by: the Lancet Commission on Migration and Health, 60 MPs, the Mayor of London, the BMA, six Royal Colleges that represent doctors and midwives, and over 100 civil society organisations.²³ They can and should be implemented now to end the Hostile Environment in the NHS and ensure genuinely universal access to healthcare.

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INTRODUCTION

The rapid emergence of the Covid-19 pandemic has thrown the world into an unprecedented crisis.

The unequal impact of the virus has laid bare the UK's structural inequalities and injustices. One of the most prominent has been the disproportionately high number of Black, Asian and minority ethnic (BAME) deaths, both among healthcare workers and the population at large. The Office for National Statistics confirms that Black people are four times more likely to die than white people, and Bangladeshi or Pakistani groups three times more likely.¹ A preliminary study into deaths among the NHS and social care workforce also found vastly disproportionate mortality rates among BAME staff, and among all staff not born in the UK.²

Decades of structural and institutional racism has meant that BAME groups are more exposed to the effects of coronavirus and are less able to protect themselves from contracting it. Government policies which disproportionately affect BAME and migrant communities, along with the existence of structural racism, has resulted in poverty, precarious employment and overcrowded housing being more prevalent amongst BAME groups. These socio-economic conditions are known to drive the comorbidities that increase susceptibility to the virus and make it harder to socially distance effectively.

There are concerns that migrants, who are predominantly from BAME groups, are experiencing the effects of such inequalities acutely during the pandemic. The Government's Hostile Environment immigration policies - which restrict access to public services and criminalise everyday activities - are likely to be contributing to the crisis. A range of organisations and elected representatives have raised concerns about the harmful impact of NHS charging policies and the additional barriers they present to migrants in need of healthcare during coronavirus.

These concerns were brought to the fore by the death of a man known as Elvis from Covid-19 on 8th April. Elvis was an undocumented Filipino migrant who had lived and worked in the UK with his wife for more than 10 years. Despite suffering with this illness, he had been too afraid to go to hospital for fear of incurring debts he could not repay and being reported to immigration enforcement.

Elvis's story is likely to be one among many. Migrant organisations up and down the country regularly report cases of their members being denied care or fearing to access care, often with horrific consequences. The criminalisation of migration, through Hostile Environment immigration policies, prevents many people from coming forward and their stories being made public. This lack of public knowledge creates an environment of impunity for inhumane policies, and in the context of the current pandemic, diminishes efforts to protect public health. Shedding light on these practices, therefore, is a matter of crucial public interest as well as a first step in dismantling the structures of exclusion, inequality and discrimination.

This report

In order to understand and uncover the barriers to accessing healthcare faced by migrants during the coronavirus crisis, Medact, Migrants Organise and the New Economics Foundation have undertaken new research with migrant organisations from across the UK. This report sets out the findings of the research and recommends a series of urgent measures.

We hope that this research, along with research and impact assessments conducted by others, will help guide the Government's response to this devastating crisis. Its devastating consequences will only be curtailed with inclusive measures designed to protect everyone's right to health.³

METHODOLOGY

The urgency of present circumstances and the lack of information about healthcare barriers during the pandemic made the quick collection of evidence a priority. This research sought to compile information in the shortest possible time frame.

An **online survey** was sent to a convenience sample* of migrant organisations – including organisations providing advocacy and support, legal advice and healthcare, and migrant community organisations – via a number of private lists and networks.

The survey comprised a mix of both open and closed questions probing:

- barriers to healthcare;
- the prevalence of fear of charging, data sharing and immigration enforcement in the health service;
- if and how the coronavirus crisis is impacting on willingness and ability to engage with health services; and
- knowledge of charging exemptions for coronavirus.

We then undertook **semi-structured phone interviews** with a subsection of respondents in order to gather further information. The purpose was not to try to represent the range of views provided through the survey, but instead to gather more in-depth information from a sample of those reporting barriers.

Descriptive statistics have been produced for the survey's closed questions. Open survey questions and interview findings have been analysed and presented thematically, using a framework developed inductively by multiple researchers working to identify and verify a set of themes from survey and interview responses. As much as possible, we have sought to quote submissions directly.

We have primarily approached caseworkers as their role supporting migrants provides them with detailed insights into the lives, challenges and issues faced by migrant communities. It is caseworkers who complete forms, call helplines, and undertake administrative tasks alongside affected migrants, and they are acutely aware of the circumstances and specific processes that prevent migrants accessing healthcare. Their work allows them to see the particular issues faced by individuals and to recognise trends that indicate systemic failings in policy and administrative processes. They were also able to provide information for this report without the same concerns of backlash from immigration enforcement experienced by the migrants they support.

It is important to note that many migrants, especially those whose status is most precarious, often do not receive any support from migrant organisations. The results of this research, therefore, are likely to understate the scale and depth of the issues highlighted.

*A convenience sample is a type of sampling method where the information is taken from a group of people easy to contact or to reach. There are no other criteria to the sampling method except that people be available and willing to participate.

FINDINGS

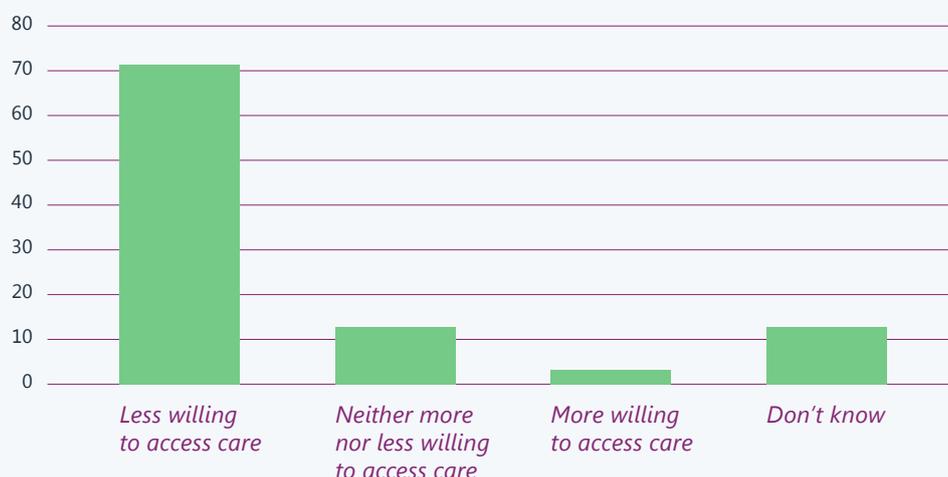
We received 70 responses from representatives of 53 different organisations, spanning London and the South East, West Midlands, East Midlands, Yorkshire and Humber, North East, North West and Wales. Each of these respondents supports numerous migrants at one time. So, while the sample of case workers is relatively small, each respondent is able to speak from their experience of supporting dozens of individuals each year.

It is clear from these responses that migrants are facing a multitude of barriers to accessing healthcare during the pandemic. Policies enacted as part of the Hostile Environment in the NHS – from charging to data sharing - are deterring people from seeking and accessing care, and the government exemptions for diagnosis and treatment of coronavirus are inadequate. For those that do come forward despite the fear created by the Hostile Environment, migrants face a range of additional barriers to accessing care. These barriers – from language and translation issues to digital exclusion – have been exacerbated by the health system’s response to the pandemic.

The result is that migrants are less willing and able to seek care. **Over 70% of survey respondents report that the coronavirus crisis has negatively impacted on migrants’ willingness to access healthcare.**

Each of these barriers, starting with the direct impact of the Hostile Environment, are outlined in turn below.

FIGURE 1:
HOW HAS CORONAVIRUS IMPACTED ON PEOPLE’S WILLINGNESS TO ACCESS HEALTHCARE (%)
 (including but not limited to GP services, hospital care, calling 111, walk-in services)



1.

The Hostile Environment deters people from seeking and accessing care

In 2012 Theresa May, then Home Secretary in the Coalition Government, announced her intention to create what she called a 'hostile environment' for migrants. The aim was to restrict access to public services and to criminalise everyday activities in order to make life unbearable for undocumented migrants living in the UK.

The Hostile Environment ushered in unprecedented levels of policing and criminalisation of services essential to living a safe and fulfilling life. Rebranded the 'compliant environment' by the current Government, the Hostile Environment includes measures that restrict access to schools, require landlords to check the immigration status of their tenants, and criminalise people for working or driving if they are undocumented. It turns nurses, teachers and landlords into border guards, and uses the data they collect to update Home Office records which are used by immigration enforcement teams to track, detain and deport people.

The overall effect is the creation of a climate of fear that extends beyond the specifics of the policies. The threat of data-sharing with immigration authorities, destitution, and ultimately deportation, combine to trap people out of the society in which they live. It has affected not only undocumented migrants and those with a precarious immigration status, but all people treated or racialised as migrants, including British BAME people and those who have lived in the UK for many decades, as demonstrated by the Windrush Scandal. The UK High Court found that the Hostile Environment directly causes and exacerbates racial discrimination in the UK.⁴

The NHS is one of the primary targets of changes brought in under the Hostile Environment. The 2014 Immigration Act changed the definition of 'ordinary residence' so that a person was required to have indefinite leave to remain in the UK to qualify for care.⁵ This was the first time entitlement to the NHS had been tied to a person's immigration status, ushering in a range of policies that have significantly changed the way the NHS operates, including:

- **The Immigration Health Surcharge.** An additional cost attached to visa applications that requires people to pay for their use of the NHS for the duration of their visa. It must be paid in full upfront, and currently the cost is set at £400 per person per year with a planned rise to £624 on 1st October 2020.
- **Upfront charging and immigration checks.** In 2017, the government introduced a statutory duty on all NHS Trusts to charge patients upfront for care that was non-urgent or did not otherwise meet an exemption from charging; in effect, imposing a requirement on NHS Trusts to formally determine a person's immigration status as a routine part of their treatment. Care that is deemed 'immediately necessary' or 'urgent' is still chargeable, with payment recovered after treatment - this includes treatment provided in intensive care and other emergency services not provided in A&E. The charging regulations include exemptions of certain groups of people and for a range of communicable diseases, including Covid-19. As we show in the evidence section below, however, the complex nature of the charging regulations, and the difficulty of proving entitlement, mean that even those entitled to care face barriers to

access in practice. Non-EEA migrants have to pay up to 150% of the cost of secondary and community care services.

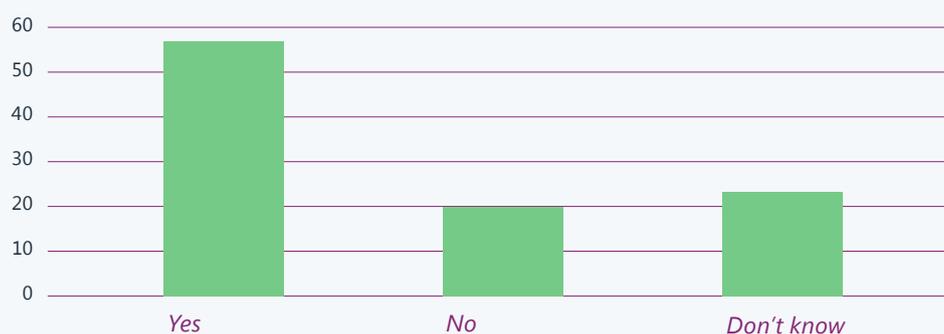
- **Data sharing with the home office.** Regulations introduced in 2015 offered guidance for NHS Trusts to report patients with NHS debt to the Home Office, which can then be used as a reason to refuse visa applications or deny entry to the country at the border. As part of determining a person's eligibility for care NHS Trusts often share patients' personal details, such as their address, with the Home Office which are then used by immigration enforcement teams.

This set of policies has faced significant opposition. The British Medical Association (BMA) has called for a full and independent review of the charging regulations, while the Academy of Medical Royal Colleges and the Royal College of Midwives had also called for their immediate suspension even prior to the coronavirus crisis.^{6,7} A national network of campaign groups working locally to oppose NHS charging and data-sharing are organising under the banner of the Patients Not Passports campaign, supported by Docs Not Cops, Medact, Migrants Organise, and the New Economics Foundation. These campaigns work alongside those directly impacted by NHS charging, such as the Justice for Simba Campaign and Windrush Action, uniting broad sections of their communities in opposition.

There is a growing body of evidence demonstrating the significant harm caused by these Hostile Environment policies in the NHS. Studies from the British Medical Association (BMA), the Equality and Human Rights Commission, and Doctors of the World show the deterrent effect of the policies on all migrants, including refugees and asylum seekers, despite them being exempt from charging under the current regulations.^{8,9,10,11}

Our research builds on this existing evidence, finding that policies enacted under the umbrella of the Hostile Environment are deterring migrants from seeking and accessing healthcare and that this remains the case during the pandemic. **57% of survey respondents report that their members or clients have avoided healthcare due to fears of being charged for NHS care, data sharing, or other migration enforcement concerns (see Figure 2).** Furthermore, in response to an open question about barriers faced by those they support, 35% list barriers directly connected to the Hostile Environment, including fears of being charged for treatment, fears of data sharing and the denial of care.

FIGURE 2:
HAVE YOUR MEMBERS/CLIENTS EVER AVOIDED SEEKING HEALTHCARE DUE TO FEARS OF BEING CHARGED FOR NHS CARE, DATA SHARING OR OTHER MIGRATION ENFORCEMENT RELATED CONCERN (%)



Ultimately the practice and perceptions of NHS charging and data-sharing, and the resultant denial of care, is leading people to delay seeking care, avoid it all together or seek informal support and medical advice.

“ [clients are seeking care] informally through the local community, i.e. nurses and other health professionals who have status are known to be providing medical care and assistance on an ad hoc basis.”

This is causing serious and long-lasting health consequences.

“ One man we supported had previously been homeless and his asylum claim had been refused. He had diabetes and did not know, he did not think he could go to the doctors as he did not have status. Because he did not receive treatment, he went blind for 6 months.”

“ One [client] had a miscarriage and had not seen any doctor because she had no immigration document. She is scared she will be taken away.”

1.1 Fear of charging and data sharing

“ Those who do not have status are fearful of approaching health services for treatment as they either fear an NHS debt which could be an impediment to any future applications, or they also fear coming to the adverse attention of the authorities.”

Charges for NHS care feature heavily in many of the survey responses. The fear of accruing large and unpayable debt is stopping people seeking care, even in circumstances where there is a clear clinical need. This is especially true for people without the means to pay, or those who fear that the presence of NHS debt will affect their application for leave to remain.

Where people have been able to access care, and subsequently discover that they are chargeable, or when the treatment becomes too costly, respondents see people “cancelling hospital operation[s] for fear of being chased for money afterwards” or withdrawing from treatment.

Respondents cite a range of negative charging experiences from those they support, with the administration of charging a significant source of concern. One respondent illustrates this with the story of “a woman [who] was visited by [a] Home Office official whilst in her bed”. Such experiences, combined with the potential to accrue further debts, act as a significant barrier to seeking more care in the future.

The following is a selection of quotes from respondents highlighting the deterrent effects of charging.

The deterrent effect of NHS charging

- “ Client had serious foot problems - swelling in the feet due to poorly controlled diabetes. The client was quite reluctant to go to hospital due to fears of being charged for NHS care.”
- “ We know of people who have delayed accessing services because of charging fears; these include scans/tests for cancer.”
- “ They're most worried about costs. Because of the large debt but also they often know it can have an impact on future immigration applications. It's also quite common for our women to want to minimise the costs by not going to all antenatal appointments and/or leaving hospital early after having the baby.”
- “ Refused, destitute asylum seekers had been told that they have to pay for secondary health care. They don't have the funds to do so, so they don't access health care for fear of the bills which will be reported to the Home Office and could cause them to be deported.”
- “ One previous client was hurt in a car accident and was collected by the ambulance. When she was in hospital, she fled before she could be treated for fear of racking up an NHS debt and being reported to the Home Office.”
- “ I teach an antenatal class aimed at asylum seekers and refugees and have come across a number of refused asylum seekers who have been charged for antenatal care. They have shared in the antenatal group that they are frightened to see their midwife again because of fear of the bills.”

NHS charging policy impacts people formally entitled to care under the regulations, through 'incorrect' upfront charging, misapplication of the exemptions, and deterrence from seeking free emergency care provided in A&E. Healthcare workers are often unfamiliar with regulations limiting migrants' access to healthcare and 'over apply' restrictions, with the knock-on effect that migrants then assume they are not entitled to care.

People 'Incorrectly' charged

- “ There is ignorance amongst health professionals of patient eligibility for [care] & ignorance amongst client group[s] about their entitlements [to] primary and secondary health care.”
- “ The charging system is not well organised. Often people with poor English, or who do not understand how the system works are considered by NHS admin. as 'visitors' and are issued with claims to pay substantial amounts of money.”
- “ We provide health advice and advocacy and have numerous examples of people being wrongly refused treatment, being charged wrongly, unable to pay bills for essential treatments and being fearful of deportation as a result.”

Respondents frequently highlight associated fears of being reported to, or identified by, immigration authorities as a result of accessing NHS care. One respondent describes a direct experience of being “tracked by the Home Office” after accessing NHS services. However, in most instances it is the possibility of data-sharing that delays or prevents people coming forward.

The deterrent effect of data-sharing

- “ They are more afraid thinking they will be handed to police/immigration enforcers. We have one asthmatic member who refused to go to A&E because of this fear.”
- “ Clients are often unclear about their rights regarding healthcare, therefore do not register with a GP or wait till accessing hospital treatment due to fears of the hospital passing information of their status or being given huge bills for treatment.”
- “ They always fear they will be arrested if they go to A&E. They are also afraid they couldn't afford to pay bills.”
- “ Enquiries by [the] Overseas Visitors team inevitably mean that the applicant's address is shared with the Home Office – so, although information given to the NHS is meant to be confidential, the Home Office can track someone's whereabouts in this way.”
- “ Women are frightened about being in contact with any authorities as they think that their details will be collected and used later to deport them. So most are managing at home. Many [are] living in very overcrowded conditions and with no independent income.”

Data sharing further exacerbates the problem of incorrect application of charging policies, with respondent's identifying that people's entitlement to access treatment “may be undermined by fear of being reported to the Home Office”.

Aaron's experience

Aaron (not his real name) is a migrant caseworker in the East Midlands, providing advocacy and support to migrants with a range of needs, from housing and education to healthcare. This support has continued during the lockdown via telephone appointments and email support.

In the area where Aaron works, there is a specialist GP surgery for refugees and asylum seekers, which makes primary care much more accessible than in other parts of the country. However, problems begin to arise when people need to be referred to secondary care. Aaron described how some of the people he supports are fearful of being charged or reported to the Home Office because of their immigration status. This leads some to avoid seeking care and worsens health.

“When people know that there may be money involved, they are scared and they don't approach it and they remain ill up until the point that it becomes critical.”

“People are scared of [data sharing], and they prefer to avoid contact.”

Aaron also described how others, who are eligible for free care and exempt from charges, are incorrectly charged, because they do not have the right documents or because staff do not understand the rules. Although these charges are often challenged and overturned, it takes time and effort from both Aaron's organisation and the health system. It causes unnecessary turmoil for the person in question and can deter them from seeking care in the future.

“Patients are not listened to, staff don't understand the [eligibility] documents and then people get a bill.”

“Now a lot of our work is calling the NHS and challenging these bills. And I say that more than half of them are waived or not properly issued.”

Respondents report that NHS charging and data-sharing leaves them in an impossible position, not knowing if advising people to access care may ultimately lead to unmanageable debt and immigration enforcement from the Home Office.

1.2 Denial of care

As well as fear of accessing services, survey respondents report instances where care has been denied because patients are unable to pay for their treatment upfront or because they have been unable to prove their eligibility for free care. One respondent, for instance, describes clients who are *“unable to access secondary healthcare treatment even though there has been a referral from the GP - this is because they are not eligible and don't have the funds to pay”*.

The charging regulations place stringent requirements on people to prove that they are in one of the exempt categories, particularly for survivors of trafficking, torture, or domestic abuse. The institutional disbelief in people's circumstances, combined with language barriers and the difficulty in obtaining the right documentation, has the effect of deterring people from seeking care altogether.

“ Accessing health services is a last resort when people are desperately ill. Usually people suffer in silence and use home remedies or if possible over counter medications. People want to limit the scrutiny they have to go through in qualifying for medical exemption.”

“ Based on our experience, initially, clients would not be overly aware of NHS charging at all, let alone categories that are exempt. They would come to realise it once charges are imposed on them or their family/friends, but then they would not be aware of certain exceptions.”

Although Hostile Environment policies primarily target secondary care, they are having a knock-on effect on other services. Respondents cite instances of GPs unwilling to refer patients to secondary care:

“ Client in [Yorkshire] was not referred to secondary care by his GP as the GP knew he wouldn't be able to pay. The GP should not be making this decision. The person should be referred to the specialist to assess if the treatment is immediate and necessary.”

“ Clients with no immigration status are barred from accessing secondary care. GPs either do not refer such individuals, or the referrals are turned down.”

There are examples of people being asked to 'prove their entitlement to care' at the door of A&E or GP practices, in contravention of NHS guidance. One survey respondent clearly identified discrimination from staff as a factor deterring people from seeking care. Another details her experience of having to prove her entitlement to care:

“ When I was pregnant, they didn't believe me that I was Polish and entitled to health care as an EU citizen. I had to send a copy of my passport to the hospital and was taken to a different room for questioning. It was stressful because I didn't know what was going on. Everything was a new system for me. ... I left that visit in tears and thought about filing a complaint. It felt like discrimination.”

One of the concomitant effects of the Hostile Environment is the proliferation of a culture in the NHS that prioritises the questioning of a persons' entitlement to care, over and above their clinical need. In practice this often leads to racial profiling, with increasing reports of assumptions about a person's entitlement or immigration status based on how they look, how they sound, or their name.

Jamal's experience

Jamal (not his real name), based at a migrant centre, works to ensure that asylum seekers and refugees have access to mainstream health services. While the centre is closed during the lockdown, support continues over the phone.

Those supported by Jamal face a range of barriers to healthcare. GP surgeries frequently require specific forms of ID and/or proof of address, which newly arrived asylum seekers often don't yet have. Some have improved their access requirements in recent months, but many have not. This means that asylum seekers have to register for a GP far from where they live, which is hard for many who cannot afford to travel. These barriers have worsened as a result of the coronavirus lockdown.

With many services and NHS facilities now physically inaccessible, Jamal and colleagues are spending a lot of time supporting clients to register for services electronically, and some GP surgeries have said that they are not registering asylum seekers.

“ Yeah, a lot of places the door is locked or the building is locked. You can't even come in to register.”

In Jamal's experience, there are signs that charging legislation has begun to introduce a culture of discrimination in the health service. For instance, whilst charging does not apply to primary care, *'it still filters down'*. Jamal has experienced receptionists not registering people because they are told that they *'could be an illegal immigrant'*, and GPs not referring patients to secondary care because they are *'not eligible for it'*.

*“ They shouldn't be making those decisions, obviously.
That language of the Hostile Environment is coming through in the GP surgeries.”*

Another man with severe mental health issues was asked why he doesn't *'go back home'* by a nurse.

2.

The coronavirus exemptions from charging are not working

In response to the coronavirus crisis, the Government has made a number of minor changes and adaptations to the NHS Charging Regulations and accompanying information for patients. On 29th January 2020, Covid-19 was added to the list of conditions exempt from charging, meaning treatment and investigations relating to it are free for all.

The DHSC issued translated advice for migrants about their entitlement to access healthcare during the crisis, but these resources were not made available until late April 2020, a month after lockdown began, and almost three months after the first coronavirus infections were identified in the UK.¹² Prior to this, the government had been relying on translated resources provided by civil society organisations, in particular by Doctors of the World.¹³

Our survey findings clearly demonstrate that these attempts by the government to mitigate the deterrent effect of the Hostile Environment during coronavirus are inadequate. Information is not adequately publicised, compound illnesses identified during a screening for coronavirus are still chargeable and charging exemptions alone are not enough to undo the damage of a decade of Hostile Environment policies.

2.1 Inadequate communication of coronavirus exemption

While treatment for coronavirus and other communicable diseases is exempt from charging, **few respondents (20%) agree that migrants are aware of this exemption** (Figure 3).

Most of those responding to the survey (56%) have not seen any information from public bodies raising awareness of migrants' rights to healthcare during the coronavirus crisis (Figure 4). Fewer still (9%) think that information about charging exemptions is reaching all sections of their communities in an accessible format (Figure 5).

Respondents point out that information about the exemption of Covid-19 had not been circulated adequately. Indeed, many caseworkers themselves do not know that it is exempt, and as such, expected that their members would also be unaware of the changes.

“ I did not know this so I imagine my clients don't.”

“ I don't think [the exemption] has been clearly explained or advertised at all.”

FIGURE 3:
MEMBERS/CLIENTS OF MY ORGANISATION ARE AWARE THAT TREATMENT FOR CORONAVIRUS AND OTHER COMMUNICABLE DISEASES IS EXEMPT FROM NHS CHARGING (%)

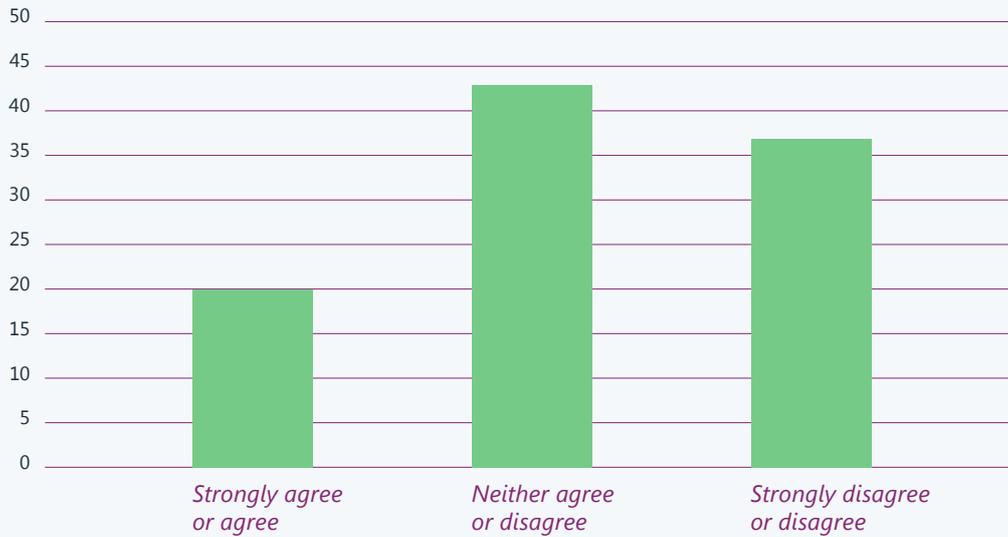


FIGURE 4:
HAVE YOU OR YOUR MEMBERS/CLIENTS SEEN PUBLIC INFORMATION FROM GOVERNMENT DEPARTMENTS, THE NHS OR OTHER PUBLIC BODIES THAT RAISES AWARENESS OF MIGRANTS' RIGHT TO ACCESS HEALTHCARE DURING THE CORONAVIRUS CRISIS? (%)

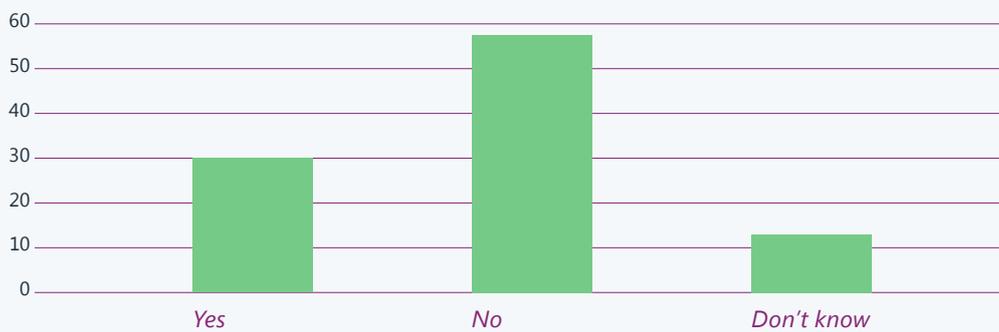
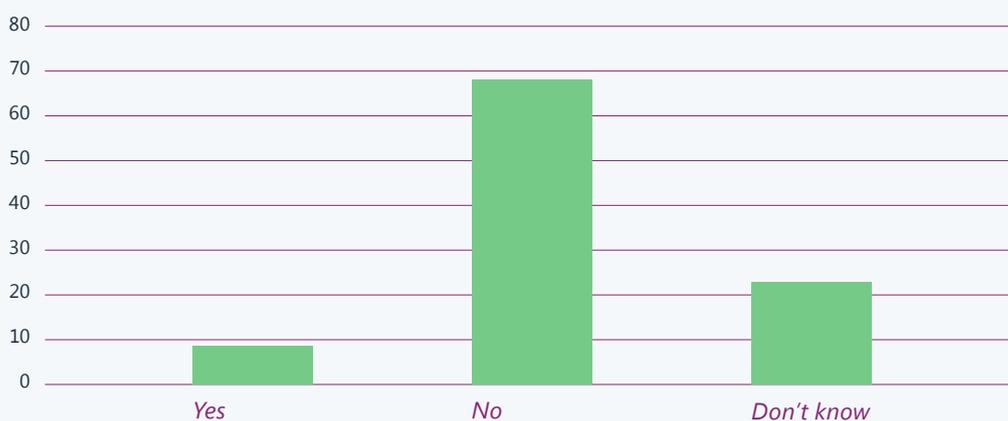


FIGURE 5:
IN YOUR VIEW, IS INFORMATION ABOUT EXEMPTIONS REACHING ALL SECTIONS OF THE COMMUNITY IN AN ACCESSIBLE FORMAT? (%)



2.2 Other charges still apply

While treatment for coronavirus is free, treatment for any other medical conditions, and all treatment received following a negative Covid-19 test result, remain chargeable upfront unless otherwise exempt. As highlighted in the section above, fear of being charged for these conditions remains a clear deterrent.

Several respondents note that:

“ there are compound issues where other illnesses could be identified during a screening which may be chargeable.”

and similarly:

“ even knowing that Covid-19 treatment is free doesn't mean that you might not end up with charges for something else.”

2.3 Fear and mistrust prevail

A decade of Hostile Environment policies mean that fear and mistrust prevail, despite the exemption, and therefore the deterrent effect persists.

“ We have spoken with our residents and made them aware [of the exemption], however there is lack of trust with the system, and they don't necessarily feel confident that this actually the case, despite our reassurances.”

“ Although I and others try to tell people [about the exemption] and publicise, general fear created by Hostile Environment [is] prevalent within communities.”

“ Even [when] we tell them this, their fear dominates.”

This is compounded by fears of data sharing and immigration enforcement. The DHSC has made no assurances that patient data will not be shared with the Home Office, including for people undergoing treatment for Covid-19. The government has issued guidance that immigration status checks should not be carried out for people only undergoing treatment or investigation for Covid-19. However, it is unlikely in practice that people will be investigated or treated for Covid-19 in isolation from other health problems, making this guidance impossible to implement.

“ Even if it is exempt, the issue is that they risk becoming known to the authorities, therefore, would rather not risk it unless they absolutely have to.”

“ ...they know that should they access care, they will either get an NHS debt or be reported to the Home Office.”

“ For those who are here without leave, they will always be suspicious of involvement with any form of registering/name taking because it could be used in a different way later. I think it will be hard to overcome that lack of trust because of the inevitable worry that unlawful presence will trigger removal action.”

Cases of undocumented migrants exhibiting Covid-19 symptoms and avoiding care out of fear suggest another strategy for dealing with the current crisis is needed.

“ One client lived in a care home where she does live-in care and she has been exposed to Corona but has stated that she will not seek treatment and would rather die there than be detained.”

Furthermore, it is clear that excluding coronavirus from immigration checks is not, in fact, being applied, resulting in people still having to demonstrate entitlement to care, despite being in hospital for Covid-19. One respondent reported a case where a man receiving treatment for coronavirus was sent a letter to his home asking him to prove his immigration status and entitlement to care - despite him being a British citizen. He was still unable to talk, having only one day earlier been discharged from the ICU. The respondent commented that “it is absolutely shocking that someone who was still so sick to be sent a letter in this time ... The family were alarmed when they received correspondence from the hospital asking for proof at such a moment. They see it as racial profiling.”

It is clear from our findings that the Hostile Environment has left many migrants feeling unable to navigate the coronavirus crisis safely. Many view the threat to their wellbeing, posed by NHS charging and data-sharing, as at least equal to the threat of COVID-19 - leaving those exposed or suffer symptoms with an impossible choice.

3.

Migrants face a range of additional barriers

“ In Covid, everything has been massively exacerbated. All the original problems exist, plus it’s really difficult to navigate how the health system works now.”

For those who do come forward despite the Hostile Environment, there are a range of specific barriers to accessing care during the coronavirus crisis. Many of these existed before the pandemic, but most have been exacerbated by coronavirus and changes to the health system as a result of the lockdown.

The widespread problems of language barriers and digital exclusion, coupled with the closure of services and fears of contracting the virus, mean that at-risk migrants are left with little to no healthcare options. These barriers act concomitantly to exclude migrants from accessing care. As one respondent described, she was contacted by a very unwell woman, who spoke “little English, couldn’t explain her problem over the phone to a GP without an interpreter and was too scared to go to a pharmacy for fear of contracting coronavirus”. Survey respondents indicated that in these scenarios, people are tending to remain unwell at home.

Several of those we spoke to note that these issues cannot be separated from the Hostile Environment policies outlined in the section above. For some, the Hostile Environment has introduced a culture of discrimination into the NHS, and together with the current crisis, has provided a justification for the obstacles and deterrents faced by migrants.

“ It’s almost like the crisis is another excuse to not deal with the patients that are considered more difficult to help.”

“ For me that was just another example of the way that the Hostile Environment has become embedded in the health services. you know, ‘you shouldn’t be our problem.’”

A brief discussion of these barriers follows. For a more detailed analysis of barriers, see Doctors of the World’s *Rapid Needs Assessment of Excluded People in England during the COVID-19 pandemic*.¹⁴ While they have been separated for clarity, respondents frequently described these barriers operating together to prevent access to care.

3.1 Closed or limited services

The cancellation of many ‘non-essential’ appointments and operations, the closure of some in-person services (particularly dentistry and GP surgeries), and other services being stripped to a bare minimum, were all cited in our survey as reasons for migrants not being able to access care during the coronavirus crisis. One respondent describes a situation where:

“ one of my clients went two weeks without a prescription. The GP practice had cancelled her appointment due to coronavirus, told her to collect her prescription from reception, then when she went there, told her to go to A&E (as far as she understood) but she didn’t go because she was frightened of Coronavirus.”

Services specifically available for migrants have been significantly limiting their practices, or closing altogether. One respondent reports that:

“ GP surgeries have interpreted the fact that a Local Enhanced Service for asylum seekers is suspended as ‘registration of asylum seekers is suspended’ and one surgery sent a pregnant woman to another surgery to register instead. It took a number of interventions from myself to get her registered at her local surgery. Just another detail - the surgery’s door was locked.”

3.2 Language and digital exclusion

During the coronavirus crisis, many health services are being administered online or over the phone, including: all health information and guidance; GP registration and booking; and support to access services. Many migrants face digital exclusions and language barriers, which make accessing health services in this way extremely difficult.

Language barriers were one of the most frequently cited barriers amongst respondents, particularly the lack of translated materials and scarcity of interpretation services. Several respondents reported that, in contravention of NHS England guidance, migrants are frequently asked to pay for or provide their own interpretation services.¹⁵

Migrants also face particular barriers to accessing the internet and telephones. Digital exclusion is particularly prevalent for migrants who are destitute, including many asylum seekers who are provided with only £37.50 a week from the government, and many more who receive no support and are prohibited from working. They have extremely limited funds to top up their phones or buy additional data. Moreover, community centres, libraries, and support organisations where internet services were previously available to use have been closed as a result of the lockdown.

“ Many of them are receiving around £35 a week. So they're paying a week's income to be able to get the internet. The poorest are paying the most for the internet. And it's really because they can't get contracts, because they can't have bank accounts, because they haven't got the proof that banks would want - their passports have been taken away by the Home Office, or they don't have proof of address, and so on.”

Our research indicates that many migrants lack the material means to access health services during the coronavirus crisis. As the lockdown forces many services to operate remotely, those with limited access to the internet or phone credit can no longer use them. When migrants do contact services, they are not offered the appropriate language support to be able to access care. Below, we discuss the impact of language barriers and digital exclusions on the lack of information and guidance, the limited access to services, and lack of support services, in turn.

3.2.1 Information and guidance

Of primary concern to a number of respondents was both the lack of guidance from the government in languages other than English, and the delay in it being made available. This includes guidance on social distancing measures, Covid-19 symptoms, or the status of health services during coronavirus and how to access them.

The lack of such translated guidance has meant that NGOs and other community organisations have attempted to fill this gap. Several respondents cited the vital translated guidance produced by Doctors of the World. One respondent reports that:

“ Lack of translated information getting out to clients on a mass scale has prevented this message getting across in a timely manner. PHE [Public Health England] and Gov.uk have minimal languages translated into advice.”

NGOs, including frontline migrant services and community organisations, have worked to translate much of the government guidance into languages spoken widely by the communities they serve. However, the government's rapidly changing and shifting guidance has presented huge challenges for those trying to disseminate this information to migrant communities. These organisations are not resourced to regularly translate information, given the time it takes and the difficulty in disseminating this information while social distancing. Also, many community centres and spaces, where people might traditionally acquire information, have been closed.

“ Most information is only available in major languages, and is hard to get in smaller community languages. Also many of my patients are illiterate in their mother tongues so have to rely on verbal communication, which is not always available.”

Where translated guidance is available, respondents expressed doubts as to whether it is reaching the migrant communities who need it. One respondent noted that “resources [are] available in different languages, but distribution is relied on by staff and key workers in the field rather than accommodation providers”.

Several respondents find that a lack of access to the internet and/or telephones has been made even more problematic during the pandemic, since most information has been distributed digitally.

“Lack of access to phones, phone credit, IT is a major barrier to people getting information. We have had to move our services online and to the phone rather than face to face - phone or and WiFi access is absolutely essential but far from universal.”

“Most asylum seekers have no access to the internet, neither do they have a TV or radio so they are in the dark and don't know how to access healthcare during coronavirus.”

The lack of formal guidance reaching migrant communities seems to have presented new opportunities for inaccurate information to circulate. Respondents report individuals being reluctant to attend appointments for blood tests or tuberculosis testing due to a misguided understanding of current advice. Others report “information spreading around that they are better off at home than in hospital”, often without a clear or formal reference point for such information.

3.2.2 Limited access to services

Language barriers and digital exclusion are also significant additional hurdles for many migrants attempting to register for, book, and access services during the coronavirus crisis. The lack of online access means that many are unable to attend virtual appointments and consultations, or access the medications they need.

“Our clients near enough all have a phone, but they don't have very much money for data. And even for phone calls, hanging on the end of a phone line that is costing them money is a real issue. They often drop in and out of having enough money on their phones. So the GP calls them back two hours later and they've run out of phone credit. Really little things like that make it very, very difficult.”

“Some people have been offered video consultations but do not have laptops or WiFi that would allow them to take this up.”

Respondents report that the people they were supporting have “no access to [the] internet or laptop to renew prescriptions”, and their “GP [is] requesting video consultation to order prescriptions - requiring a smart phone and internet access”.

Respondents also report that housing conditions for many migrants compound the difficulties of accessing care online as WiFi is rarely provided in asylum accommodation, and crowded conditions mean that confidentially sharing medical information in these settings can be difficult.

“As most healthcare appointments are now happening via telephone/ videoconferencing, this is proving a significant barrier for our clients who often do not have access to smart phones/ internet or do not have adequate privacy to discuss healthcare concerns due to shared/ cramped accommodation.”

For those that do have access to a phone or computer, language barriers are exacerbated by online and telephone formats. Prior to the crisis, many would overcome the language barrier by physically visiting GP surgeries with friends or family who could translate for them, or attempt to be understood until an interpreter could be located. Online services, by comparison, are exceptionally difficult for people who do not speak English:

“ Phone consultations are no good for people with broken English.”

“ Lack of use of interpreters means people are not able to explain themselves over the phone to health professionals. GPs who previously had interpreters booked by admin staff seem unable to do so themselves from a remote setting.”

A particular problem during the crisis is automated phone systems, which do not offer alternative languages to English. It is often impossible to convey a health concern without first navigating complicated triage systems over the phone, in a language that the patient does not understand. Even where patients are able to speak to an operator, our research reveals that in GP practices receptionists and other administrative staff use interpretation services even less frequently than health professionals.

“ Receptionists [are] not using interpreters, and receptionists don't have patience to explain procedures to patients.”

As well as GP services, several respondents cite language and interpretation barriers to accessing the NHS 111 service. For several weeks, the Government's advice for those displaying coronavirus symptoms was to call 111, yet several respondents report “not knowing if 111 have interpretation services”. Migrants who were made aware of interpreters available through 111 nonetheless indicated that there were problems with “calling 111 but interpreters not being available and when available difficult to use”.

Margaret's experience, highlighted in the box below, provides an example of the difficulty in accessing the interpretation services of 111.

Margaret's experience

Margaret (not her real name) works for a London-based charity supporting migrants to navigate and access the health service effectively. Before coronavirus, Margaret's clients faced many barriers resulting from a lack of interpretation services and difficulty registering with a GP due to the documentation required.

“ People turn up to primary care or A&E or whatever, and they can't speak the language. I think that always has to be the prime one [barrier]. We are not very good as a healthcare system at providing interpreting services for that.”

With appointments going online or held over the phone, language barriers and digital exclusions have intensified. Margaret described the practices of a GP surgery in a diverse part of London...

“ The practice gate was locked, with a sign saying ‘if you think you have Covid symptoms, please go online’ [...] What about all those people who don't speak English? [...] Also, you're signposting them to an internet based service. How many of their patients do you think actually have access to the internet?”

... and the difficulties accessing 111 services without a translator.

“ There was a case of a guy who Whatsapped one of my colleagues to tell him he had chest pain, and I was quite worried about him ... I tried to contact his GP but couldn't get through ... so I said the only way we can do this is for you to call 111. He recorded the 111 conversation, which was eye opening even for me. It eventually worked out, but because of the algorithms they ask you all of these questions first. He was trying to say 'I need a Tamil interpreter, I have chest pain, fever and shortness of breath' and it was asking him which tube station he lived near. Eventually you do get put through to an operator, but it took the operator a while to work out he needed an interpreter. He then got an interpreter, which was great, but the conversation then went from bad to worse, with the interpreter getting angry with the operator because they were so determined to go down the path of yes or no answers that had no appropriateness to this poor, distressed guy. The operator had to get him an ambulance, which all worked out. But it was an eye opener for me to see how difficult it is even to talk to 111.”

In Margaret's experience, the complex nature of health care entitlements means that very few people understand how the system works; the law is often misapplied and many are concerned about accessing care for fear of being charged. This is compounded by data-sharing and letters asking patients to prove their entitlement to care.

“ Nobody understands health care entitlement... Certainly receptionists, certainly GPs, certainly patients do not understand who's entitled to what.”

Margaret is concerned about whether people are aware of coronavirus charging exemptions.

“ I don't think [my clients] particularly even make that sort of distinction [between exemptions for different types of services]. I think it's much more of a sort of 'oh my God, I'm not entitled to health care' or I am.”

3.2.3 Lack of support services

The barriers posed by the moving online of many services is compounded by the closure, or partial closure, of many migrant organisations' offices or centres.

For example, some migrants are entitled to access the NHS Low Income Scheme (LIS), allowing them to receive full or partial support for prescriptions, dental work, eye care costs, and healthcare travel costs. This should improve access to healthcare for migrants who are destitute and/or on very low income, who might otherwise be priced out of receiving healthcare. Some migrants are entitled to support from the scheme - which is demonstrated by receiving a HC2 certificate - automatically. Others must fill in a HC1 form which requires completing a hard copy of the form and providing considerable evidence of financial and other circumstances.

In normal times, many do not know that they are entitled to this kind of support; forms to access the support can be very burdensome to complete, and there are frequent delays in receiving HC2 certificates proving free entitlement to care because of the bureaucracy involved in obtaining them. During the pandemic this has worsened. Migrant organisations are less able to help with

burdensome forms over the phone, and the process has now been moved online, presenting issues for those digitally excluded. There are also further delays between applying and receiving the certificate. As a result, some are going without the funds to pay for medication, meaning that they do not collect medication they require because they cannot afford it.

“ The HC1 forms are very difficult for people to fill in if they have limited English - we normally provide face to face support with these but have to try to help over the phone at the moment.”

“ Lack of HC2 certificates and no funds to pay for medication. A HC1 form can be filled in online but most asylum seekers don't have WiFi or understand the questions.”

3.3 Accommodation and proximity to care services

The precarious living situation migrants face while in the process of acquiring their immigration status creates additional barriers to accessing healthcare, many of which have been exacerbated during the crisis. They experience higher instances of homelessness, 'sofa-surfing', and frequent moving between accommodation, often due to Home Office dispersal, provision of accommodation, and problems caused by the Right to Rent policy. This complicates access to healthcare, as many face difficulties providing the proof of address often asked for when registering to use health services, and many are forced to move away from the services where they had been receiving treatment.

Migrant support services often circumvent these problems by using the organisation's address on forms to ensure that migrants can more easily access prescriptions and receive letters. However, with lockdown, a lack of access to their physical premises makes this difficult. One respondent reports that *“One of [their] clients went without HIV meds for two weeks as [their] clinic was cancelled and meds were sent for her to our office, which then closed so she couldn't access them. She did not want to contact the clinic because she didn't want to be a nuisance”*.

Some migrants are in lockdown in areas where they don't normally live. If their GP surgery has remained open during the lockdown, this prevents them from presenting physically at the surgery.

“ Clients not being able to present physically to GP or dentist surgeries where they are not currently registered. Particularly where clients have gone to stay with friends during lockdown and then not been able to access the closest GPs.”

Some of the coronavirus response measures have further exacerbated these problems. For example, migrants who have been newly housed as part of the government programme to provide accommodation for all homeless people have now been left isolated.

“ Refused homeless asylum seekers have been moved away from their surgery if they have been housed by Local Authority [during Covid-19].”

One respondent reports working with an asylum seeker and victim of torture, who was rehoused in a hotel in Reading during coronavirus, far from his previous accommodation in South London and the GP from whom he had been receiving medication. His medication was dispensed at a pharmacy near his former address, by which time he had been relocated to the hotel. The pharmacy was

unable to post it to him. He then travelled to London by train to collect his prescription - putting himself at risk of contracting the virus, and was only able to afford the train fare with financial support from the respondent's organisation. For migrants who are in the Government's 'extremely vulnerable' group and therefore receiving additional support during the lockdown, relocation leaves them with a choice between having the physical space to isolate safely, or being close to their GP, community networks and continued support.

Respondents note incidents of asylum seekers who have become stuck in Initial Accommodation (IA) during the pandemic.¹⁶ While guidelines state that migrants should be housed in IA for three weeks or less, there are reports of people staying for months at a time, which has increased during the lockdown. Respondents reported that access to healthcare in IA is extremely limited, both due to the advice provided by private accommodation managers or due to difficulties registering for GP surgeries without a fixed address. Migrants with particular health needs are being prioritised for dispersal from IA during the lockdown, but they are dispersed to areas where they are not registered with a GP and are unfamiliar with local services and support systems.

“ *Dispersals of Asylum Seekers are continuing for vulnerable families and [service users] with health needs but we are struggling to get prescriptions issued as there are no face to face consultations and GP's are reluctant to prescribe for patients they have not met in person with no medical history.*”

3.4 Fear of contracting Covid-19

The final major obstacle to accessing healthcare identified in our research is a direct result of Covid-19, with respondents noting that people are not seeking healthcare, or are more reluctant to, for fear of contracting the virus. This exists even in cases where people are unwell. As two respondents highlighted:

“ *people are very anxious to access healthcare due to ongoing risk of catching coronavirus e.g. not attending hospital even when very unwell due to concern about risk.*”

“ *People we talk to are less likely to go to the doctor or the hospital. Some who have been sick are afraid of getting more sick by going to the hospital.*”

One healthcare professional describes how many of their migrant patients...

“ *are not always aware that healthcare can be accessed remotely, or will be managed safely if they need to attend in person, so seem to think that there is too much risk attached to expressing that they are unwell in any way for fear of contracting the virus.*”

Another respondent describes a case where “[an] asylum seeker I know contacted me in a panic as her son had cut his face, and she didn't know if it was still possible to go to A&E, and couldn't get a response from 111”.

Our research also uncovered that many respondents link fear of contracting coronavirus with fears of receiving discriminatory care or treatment from the NHS. This cannot be decoupled from past experiences of using the NHS and other public services, in which many migrants have faced discrimination based on immigration status or race, having to prove their entitlement to care whilst others do not.

One respondent, who works predominantly with asylum seekers from North Africa, reports that:

“ someone with [a] cough said they can't ring 111 even when they get worse because the hospital will neglect them because of who they are. So although she's aware it's free but thinks she don't deserve it - that they won't prioritise her.”

Further, the fear of discriminatory treatment has been exacerbated by the disproportionate number of BAME deaths due to coronavirus in the UK, including the disproportionate number of migrants who have died - both amongst NHS staff, and the population at large. In our research, it was clear that this has added to the fears amongst migrants of seeking treatment for coronavirus. One respondent explains that migrants they work with “are scared of contracting coronavirus in hospital ... as many migrants are dying from the virus, people feel they will not get good care”. Other alarming responses noted that people are less likely to seek care during the crisis because they “feel that they are not part of the British community”.

WHAT NEEDS TO CHANGE

This report adds to the growing body of evidence that policies implemented as part of the Hostile Environment are preventing migrant communities in the UK from accessing the healthcare they need. This continues during the coronavirus crisis despite efforts by the government to exempt treatment for Covid-19 from charging. Fear, created through a decade of exclusionary policies, continues to deter people from seeking care. Our findings reinforce the concerns that have been put to the Minister of State for Health and Social Care and to the Home Secretary in letters signed by 60 MPs, the Mayor of London, the BMA, six Royal Colleges that represent doctors and midwives, and over 100 civil society organisations; and justifies the longstanding opposition to the policies that precede the present crisis.^{17,18,19,20}

The government has yet to acknowledge the ineffectiveness of the exemption for Covid-19, and has expressed little interest in investigating any potential deficiencies in its policies or the impact they are having. In response to the concerns raised by parliamentarians, unions, and civil society, the government merely reiterated that Covid-19 was exempt and that, many weeks into the pandemic, they would eventually “be publishing information about the free treatment of coronavirus in around 40 different languages”.²¹ This delayed and inadequate response has undoubtedly contributed to the confusion and disinformation recorded in this report.

For those that do come forward, there are a range of additional barriers that affect migrants' ability to access healthcare. These barriers – from language and translation issues to digital exclusion – have been exacerbated by the health system's response to the lockdown. They also cannot be separated from the Hostile Environment, which has introduced a culture within the NHS which accepts the existence of such barriers and provides a way to justify the denial of care to people racialised as migrants. This is not to say that there are not many NHS staff working to support people to access care and, where possible, to circumvent the barriers put in place by the Hostile Environment. However, these actions alone are not enough to mitigate the fear created by these policies, or to ensure the safety of people accessing services which systematically share data with immigration enforcement. Avoidance of healthcare, for fear of contracting Covid-19, is exacerbated by the disproportionate number of migrant and BAME deaths, and a fear that they, as migrants, will not receive good quality care.

While we have classified these policies and practices as ‘barriers’, they might equally be described as structural weaknesses in the system of care provision. By undermining the relationship between health services and a significant portion of Britain’s migrant and BAME populations, the Hostile Environment has made the NHS less resilient to shocks and emergencies. The World Health Organisation has repeatedly emphasised that long-term management of the pandemic requires the building and maintenance of trust: trust by the public in the decisions made by governments, trust by governments that the rules they set will be adhered to, and clear communication to prevent misunderstanding or lack of clarity on what needs to be done and by whom.²² By its very nature the Hostile Environment undermines trust in public services, removing from Government the most essential mechanism required for fighting the crisis.

It is clear that the Hostile Environment is incompatible with the role and functions of the NHS. It works to create and reinforce the perception that certain groups of people are not entitled to access vital public services. Through misinformation and misapplication, and the mobilisation of fear, the policy creates a hostility that discourages people from seeking care. This hostility, and the structural nature of the exclusions it establishes, are likely to have contributed to the disproportionate number of BAME deaths during the coronavirus crisis.

The findings of this research demonstrate that current exemptions, as well as the Government’s emergency pandemic policies, are not working. We conclude, in line with recommendations set out by the Lancet Commission on Migration and Health as well as many others, that the only way to address these failures is to end the Hostile Environment in the NHS altogether. This will entail:

1. **Withdrawing all NHS charging for migrants**, in particular the National Health Service Overseas Visitor Charging Regulations 2015 and 2017 and the Immigration Health Surcharge.
2. **Ending all data sharing** between the NHS and other health services, and the Home Office. The government should implement a firewall to ensure that patient data will never be shared with the Home Office or other bodies for the purposes of immigration enforcement.
3. **Launching an information campaign** to ensure both NHS staff and the public are aware of these changes and that it is safe for people to seek care. It should be done with a particular focus on migrant communities across the UK with the intention of undoing the deterrent effects of the Hostile Environment. It should also inform people about their right to access translation services and translated guidance throughout their engagement with the NHS, and impress upon NHS Trusts their requirement to meet this need.

These measures are urgently needed. They echo the recommendations made by: the Lancet Commission on Migration and Health, 60 MPs, the Mayor of London, the BMA, six Royal Colleges that represent doctors and midwives, and over 100 civil society organisations.²³ They can and should be implemented now to end the Hostile Environment in the NHS and ensure genuinely universal access to healthcare.

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Whilst this report highlights many negative experiences of migrants, there are thousands of positive experiences of migrants accessing healthcare around the country, and a separate report could be written on the efforts of NHS workers and bodies to facilitate such care despite the barriers thrown up in their path. Indeed, there are many migrants who owe their lives to the NHS and who are quietly carried through the system by the NHS employees who refuse to abide the unjust structures into which they are being coerced. These remarkable efforts, which will likely never be publicly known, represent the best of what the NHS stands for and will one day be spoken of with pride. This report is dedicated to them.

Endnotes

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