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Structural barriers to refugee, asylum seeker and undocumented migrant healthcare access. Perceptions of Doctors of the World caseworkers in the UK



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ABSTRACT

This article contributes new insights into how refugees, asylum seekers and undocumented migrants experience access to healthcare in the UK from both the perspective of caseworker volunteers and the assessment of policy regulations that influence such experiences. Drawing on material taken from qualitative interviews conducted with Doctors of the World caseworkers and Freedom of Information documents from NHS trusts, we reveal the various complexities faced by refugees, asylum seekers and undocumented migrants when trying to access vital health care. These issues include, charging regulations, the refusal to register patients at GP practices without proof of ID, language barriers and complications navigating the healthcare system. We found that such deterrents lead to risky help and health seeking, lack of or inadequate healthcare, and worse health outcomes among these populations. DOTW caseworkers perceived policies such as charging regulations, to be unjust as they plunge patients into significant debt, which is reported to the Home Office and can lead to the detainment or deportation of patients and their families. Study participants called on the UK government to recognise health as a fundamental human right, to develop inclusive social policy and to create an empathetic health system that allows refugees, asylum seekers and undocumented migrants equitable access to health and social services. To achieve health for all, they argued the need for clearer guidelines regarding access to healthcare and charging regulations, with some suggesting the importance of revising current Department of Health and Social Care policies and Home Office measures. Our article concludes that there is a need to tackle the underlying causes of ill health, including discriminatory policies, racism, and exclusion; addressing the social and economic determinants of health; and providing meaningful and culturally sensitive healthcare and social support.

1. Introduction

This article explores how refugees, asylum seekers and undocumented migrants experience access to healthcare in the UK from the perspective of caseworker volunteers at Doctors of the World (DOTW) and through the assessment of policy regulations that influence such experiences.

This research is timely as armed conflicts are increasing around the world (Nester, 2010) and we are witnessing the highest levels of displacement on record (Murray et al., 2002; Pedersen & Kienzler, 2014). The latest estimates by the United Nations High Commissioner for Refugees (UNHCR, 2020a) suggest that, as of December 2020, there are approximately 82.4 million forcibly displaced people (including 48.0

million internally displaced people) as a result of persecution and human rights violations, wars and conflict, natural disasters, climate change, and economic hardship. In the UK, it was reported there were 135,912 refugees, 83,489 pending asylum cases and 3968 stateless persons as of mid-2021 (UNHCR, 2021). There were also 48,540 asylum applications made in the year ending December 2021 (Refugee Council, 2022). The exact number of so-called undocumented migrants is unknown, however recent estimates by the Pew Research Centre (Connor & Passel, 2019) and Greater London Authority (Jolly et al., 2020) state that there were between 594,000–745,000 undocumented migrants in the UK in 2017.

According to the 1951 Refugee Convention, UNHCR defines refugees as 'persons who have escaped their country due to war, violence, persecution or natural disaster'. They are recognised as being unable to

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return home because it is too dangerous, so they require sanctuary elsewhere (UNHCR, 2020). Asylum seekers, are defined under Article 3 of the European Convention on Human Rights (ECHR), as persons who have left their home countries as political refugees and made an application for asylum in another country, but their application status has not yet been finalised (UNHCR, 2020). The term undocumented migrants is commonly used to refer to people residing in a country without the legal right to do so (The Migration Observatory, 2021). Undocumented migrants live in limbo, facing risk of detention and deportation, labour exploitation, precarious working roles - including prostitution, modern slavery, and limited or lack of access to essential services, such as healthcare (Bragg & Feldman, 2011; Bloch, 2001; Monforte & Dufour, 2011; Vernon, 2012; Bloch, 2013; Woodward, Howard, & Wolffers, 2014a; Keith and Ginneken, 2015).

Reports have highlighted that refugees, asylum seekers and undocumented migrants face major difficulties accessing public and specialist healthcare in the UK. This has been specifically linked to so-called 'hostile environment' policies, introduced by the then Home Secretary Theresa May in 2012. These policies span the social, welfare, benefits and healthcare systems to restrict 'illegal' migrants from accessing basic services, thereby, forcing them to leave the country voluntarily (Webber, 2019). In relation to the National Health Service (NHS), one way hostile environment policies were integrated into the system was through the Charges to Overseas Visitors Regulations 2015 and 2017 amendment (PatientsNotPassports, 2020; Worthing et al., 2021). This provided a mandate for charging overseas visitors for secondary care, including those without regularised immigration status and refused asylum seekers (Hiam et al., 2018; Weller & Aldridge, 2019). If persons are unable to pay upfront, treatment is refused unless considered 'urgent' or 'immediately necessary' (Giacco et al., 2014; Suphanchaimat et al., 2015; Worthing et al., 2021).

In addition to charging regulations, ID and documentation checks at GP surgeries further restrict access to basic healthcare services (Scott et al., 2019; Stagg et al., 2012) as registration is frequently denied those unable to provide such documentation (Hiam et al., 2018; Weller & Aldridge, 2019; Worthing et al., 2021). A further deterrent is the NHS data sharing practice and requirement. Until May 2018, the NHS Digital Data Sharing policy existed. This asked NHS trusts to systematically share patient data with the Home Office for immigration enforcement purposes (DOTW, 2018; Papageorgiou et al., 2020; PatientsNotPassports, 2020). In spite of this policy now being discontinued, data sharing practices continue in less formal ways (see below).

Despite these insights, there is only scarce research available about how legal rights of refugees, asylum seekers and undocumented migrants influence decisions about healthcare utilisation and provision, regardless of the clinical needs of patients. To begin addressing this knowledge gap, we analysed qualitative interviews with caseworkers volunteering for DOTW UK, and Freedom of Information request (FOIs) documents with a focus on healthcare access, provision and utilisation among refugees, asylum seekers and undocumented migrants. Our data reveals how discriminatory policies can lead to practices that exclude refugees, asylum seekers and undocumented migrants from using fundamental services provided by the NHS and, thereby, cause adverse physical and mental health outcomes among these communities.

Based on these findings, we argue that practices engendered by the UK's hostile environment are structurally violent in that they further exacerbate fear surrounding health seeking and can, consequently, lead to poor health outcomes. Structural violence refers to "preventable harm or damage to persons (...) where there is no actor committing the violence or where it is not practical to search for the actor(s); such violence emerges from the unequal distribution of power and resources or, in other words, is said to be built into the structure(s)" (Weigert, 2010, p. 126). That is, it reflects the deep structural roots of health inequities caused by social, economic and political systems that prevent persons from achieving their full potential, meeting their basic needs, and experiencing good health and wellbeing (De Maio & Ansell, 2018;

Farmer, 2004; Farmer et al., 2006). Considering the structurally violent effects of the UK's hostile environment policies, we further argue that they stand in direct conflict with the human right to health outlined in WHO's 1946 constitution, stating that "every human being has the right to the enjoyment of the highest attainable standard of physical and mental health" (WHO, 2017).

To address this grievance, we call for a more empathetic asylum and healthcare system which provides the best possible care for all by prioritising those furthest behind and most disadvantaged in society by taking into account their particular social, economic and legal situations. This, we conclude, requires a holistic, human rights-based approach, focusing on three interrelated areas of work: (a) tackling underlying causes of ill health, including discriminatory policies, racism and exclusion; (b) addressing the social and economic determinants of health; and (c) providing meaningful and culturally-sensitive healthcare and social support.

In the following, we provide additional background information on the nexus between migration and health and the health situation of refugees and migrants in the UK; outline our methodological approach in detail; and present and then further discuss, the results of our study guided by the arguments outlined above.

1.1. The nexus between migration and health

Displaced populations encounter violence, discrimination and suffering in their home countries, on their travel routes, and in host countries. This experience has been linked to detrimental health and mental-health outcomes (Droždek and Wenzel, 2018; WHO, 2018).

In their home countries, many are exposed to poverty, food shortages, loss and bereavement, armed conflict and violence, including sexual violence and torture, with limited health care and social support (Killikelly et al., 2018; Liebling-Kalifani et al., 2013; Lori & Boyle, 2015; Shultz et al., 2014; Silove et al., 2017; Singer & Massey, 1998; Taylor, 2009). On their journey, refugees and migrants may continue encountering horrific experiences such as starvation, maltreatment and exploitation, trafficking, rape and detention (Araujo et al., 2019; Hynes & Cardozo, 2000; Krämer & Fischer, 2019; Leaning et al., 2009; Massey et al., 2016). Recent reports also highlight drowning, hypothermia, heatstroke and dehydration as refugees attempt to cross the Mediterranean in search for safety on the shores of Europe (IOM, 2019; UNHCR, 2019; WHO, 2018). Overall, such experiences complicate pre-existing health conditions like infectious and chronic diseases, as well as mental health problems including post-traumatic stress disorder (PTSD), depression and anxiety triggered by trauma (Abbas et al., 2018; Dowling et al., 2019; Gerritsen et al., 2006; Matlin et al., 2018; McFarlane & Williams, 2012; Ventevoel et al., 2012).

Upon arrival in host countries, refugees and migrants often live in precarious conditions until asylum is granted. Refugee camps and Immigration Removal Centres are challenging due to overcrowding and inadequate sanitary conditions, and are environments where communicable diseases can spread quickly, and mental health and psychosocial conditions often go untreated (Dourgnon & Kassas, 2014; Gerritsen et al., 2006; Hassan et al., 2016; Jones, 2017). Additionally, refugees have the added challenge of adapting to the new sociocultural norms of host societies where they face structural violence in the form of racism, discrimination and marginalisation (Boswell, 2003; Kang et al., 2019; Matlin et al., 2018; Maydell-Stevens et al., 2007). Such discrimination detrimentally affects other social determinants of health including, but not limited to, poverty, poor living and working conditions, unemployment, and access to public services, such as education and healthcare (Norredam et al., 2006). Access to healthcare is further complicated due to discriminatory policies, such as charging regulations, language and communication barriers (Allsopp et al., 2014; Crawley et al., 2011; Droždek & Wenzel, 2018; Sampson et al., 2016; Ventola, 2014).

1.2. The health situation of refugees and migrants in the UK

Longitudinal studies conducted in the UK among refugees, asylum seekers and undocumented migrants, have demonstrated that their health deteriorates over time (Jannesari et al., 2019; Rowley et al., 2019; Turner et al., 2003; Woodward et al., 2014b). This has been attributed to untreated, pre-existing health conditions, inadequate living conditions, and the avoidance of seeking healthcare due to cost and fear of being detained (Allsopp et al., 2014; Bogic et al., 2012; Perraudin, 2017; Taylor, 2009). Receiving adequate healthcare in the UK has proven challenging for refugees, asylum seekers and undocumented migrants as healthcare entitlement does not mean healthcare eligibility (Finnerty et al., 2019; Legido-Quigley et al., 2019; Page-Reeves et al., 2013; Tomkow et al., 2019).

In England, for instance, healthcare entitlement can vary across different groups and services. Primary care, including GP and nurse consultations, are free of charge for all, regardless of people's immigration status or income (GOV.UK, 2019). Other free services include access to Accident and Emergency (A&E), family planning services, the diagnosis and treatment of infectious and sexually transmitted illnesses, and treatment of conditions caused by torture, trafficking, domestic violence, and female genital mutilation.

With regard to secondary care, refugees, asylum seekers and undocumented migrants have different rights depending on their legal status. Those with registered refugee status, with asylum applications in process (including appeals for previously rejected claims), and people receiving support under Section 95¹ are eligible for free treatment (GOV.UK, 2021a). Refused asylum seekers and undocumented migrants, on the other hand, have to pay for secondary care (Russell et al., 2019). In practice, however, these differences in status and healthcare eligibility are often either conflated or not explained, causing confusion for those trying to access care (O'Donnell et al., 2007).

Difficulties in accessing and receiving healthcare are further exacerbated as the right to healthcare for everyone is not fully guaranteed in the UK. A study carried out by DOTW UK (2016) found that four out of every five patients seen at their London clinic are denied GP registration despite being entitled. This has been because health seekers were unable to provide documents such as IDs and visas, despite NHS England guidelines clearly stating that GP practices are not required to ask for proof of identification from patients wishing to register (GOV.UK, 2019). This is a hangover from the now out-dated 2017 policy when the Home Office released its 'access to NHS patient records policy' that permitted the viewing of patient home addresses and GP details (Papageorgiou et al., 2020; Waterman et al., 2021). This data-sharing agreement was designed to track down 'illegal' immigrants residing in the UK and has been described as creating an 'atmosphere of fear' where most undocumented migrants were too scared to register with a GP or access emergency treatment for fear of being found and detained by the Home Office (Bartlett, 2018; DOTW, 2017). Although the government withdrew the data sharing Memorandum of Understanding in late 2018, data sharing still occurs in a number of ways through guidelines required by the government itself (DOH, 2019; Russell et al., 2019; GOV.UK, 2019). It could be argued that the NHS itself contributes to this ambiguity stating on its website: "You do not need proof of ID to register with a GP, but it might help if you have one or more of the following: passport, birth certificate, HC2 certificate, rough sleepers' identity badge, hostel or accommodation registration or mail forwarding letter" (NHS, 2020).

Another tool deterring refugees and migrants from accessing healthcare in the UK is the overseas charging regulations for non-European Economic Area (non-EEA) nationals, as well as nationals from the EU, Iceland, Norway, Liechtenstein, or Switzerland who have entered the UK

after January 1, 2021 to live, study or work for a period of 6 months or longer (GOV.UK, 2021b) including undocumented migrants and failed asylum seekers, unless their health problems are deemed 'urgent' or 'immediately necessary' (NHSE, 2019).² Charges for secondary care are 150% of the cost of regular NHS care (GOV.UK, 2019). Such high costs can lead to a delay in seeking healthcare or not seeking it at all, and can also plunge migrants into significant financial debt (Nellums et al., 2018a, 2018b). Any NHS debts or outstanding bills over £500 that are not paid within three months have to be reported to the Home Office (Worthing et al., 2021) and can influence any future immigration applications, including current asylum applications and/or appeals.

We consider these structural barriers to healthcare unjust as they are in direct contradiction to Article 25 of the Universal Declaration of Human Rights (UDHR), which states that every citizen in the world is entitled to healthcare. Specifically, the right to health for all individuals means, "that everyone should have access to the health services they need, when and where they need them, without suffering financial hardship" (Adhanom, 2017; WHO, 2017, pp. 8–11). Little is known, however, about how these barriers influence not only the access to healthcare, but also the provision of health services and health outcomes among migrants and refugees in the UK.

2. Methods

We adopted a qualitative approach to explore how immigration policies and government guidelines for charging overseas visitors have impacted access to healthcare and health outcomes for refugees and undocumented migrants. Qualitative research can produce rich data taken from the perspective of research participants, allowing for new ideas and insights to emerge that, in turn, can be used for further research into recurring themes (Al-Busaidi, 2008). Following this approach was appropriate for our study as it provided a deeper and more holistic understanding of healthcare providers' views on government policies, healthcare access, treatment, and care among migrant and refugee populations (Lincoln, 2005).

Our study was conducted between June and August 2017 using semi-structured interviews and the analysis of FOI documents. These two approaches were considered to be complementary in that they allowed us to generate a more complete picture of the political landscape related to healthcare access for refugees, asylum seekers and migrants. While the interviews provided first-hand professional experiences and perceptions of caseworker volunteers, the FOIs gave insight into existing policies and protocols used by NHS Trusts to charge patients and provide healthcare.

2.1. Semi-structured interviews

The first author conducted semi-structured interviews with caseworkers volunteering at DOTW in their East London clinic. At the time, she also volunteered as a caseworker at the charity. Her dual role as researcher and caseworker meant that she not only gained in-depth insight into the day-to-day workings of DOTW, but also supported refugees, asylum seekers and undocumented migrants in navigating the UK healthcare system, including its policies and guidelines. However, these insights are not featured in the results section as no ethical approval had been obtained to conduct research with displaced populations. Nevertheless, it needs to be acknowledged that some of these insights likely shaped the interpretation of the findings and recommendations considering that it is difficult to fully distance oneself from insights gained at the workplace despite critical self-reflection.

DOTW is an independent registered charity in England and Wales. Its

¹ People seeking asylum can access this support in the form of housing and/or basic living expenses while in the UK through a scheme administered by the Home Office.

² Immediately necessary treatment is care that is promptly required to save the patient's life or prevent a condition from being life-threatening. Urgent treatment is where care may not be immediately needed, nevertheless cannot wait till the individual is expected to leave the UK (BMA, 2021).

aim is to empower marginalised groups, particularly refugees, asylum seekers and undocumented migrants to access healthcare. Services provided include mainly medical check-ups, sexually transmitted infection screenings, women and children's clinic, and monthly tuberculosis screenings.

In London, DOTW delivers its services through volunteer health and case workers. These volunteers were included in our study as they could provide first-hand insights into the difficulties and challenges experienced by refugees, asylum seekers and undocumented migrants when trying to access or receive NHS care, and furthermore how immigration policies shape the way healthcare is provided.

The sample among the volunteers was obtained through a purposive-convenience sampling approach. Prior to contacting potential study participants, permission to carry out the study was formally obtained from DOTW's research panel. Thereupon, potential interviewees were sent an invitation email, including a detailed information sheet to help them make an informed decision regarding participation in the study.

The sample consisted of six female caseworkers and clinic support workers. They were mainly university students and graduates working in health-related fields. Their specialities included conducting social consultations with service users to determine their needs and provide appropriate advice and support, liaising with NHS bodies, advocating on behalf of service users, and other outreach work, such as making referrals to specialised charities. One of the participants was a former NHSE trained doctor, working as the DOTW mobile-clinic coordinator at the time of the interview.

Our topic guide inquired into participants' knowledge regarding immigration and charging policies, healthcare entitlements, and resources and barriers to accessing care and how these structures impact the physical and mental health of refugee and undocumented migrant populations in the UK. All interviews were carried out face-to-face except for one which was conducted via Skype. With the permission of the participants, the interviews were audio-recorded and transcribed verbatim.

2.2. Freedom of Information (FOI) requests

Additionally, FOIs were made to gain insight into the protocols being followed by NHS England (NHSE) trusts in relation to charging guidelines. FOIs are part of the Freedom of Information Act (FOIA) which allows individuals the right to access recorded information held by public sector organisations. The sample of institutions from which FOIs were requested consisted of individual NHS England trusts which were found on the NHS UK website.

The trusts were selected using the latest immigration statistics published in May 2017 to determine locations with a large population of asylum seekers. It was assumed that if there were significant numbers of asylum seekers housed in these areas, it was reasonable to imagine a similar pattern of refugees, asylum seekers and undocumented migrants living there as well. The list was further condensed down to include only England, from which 30 NHSE trusts were selected at random for the research project. FOI requests were sent to individual trusts asking two key questions: (1) What policies, guidelines, protocols or standard procedures are in place to support staff to identify and then charge overseas visitors? This includes guidelines/protocols/procedures: (a) used to identify those who are potentially chargeable (under NHS charging provisions); (b) used to identify vulnerable/exempt groups; and (c) to identify those with asylum applications under process during the time chargeable care was accessed. (2) What policies, guidelines, protocols or standard procedures are used by the hospital trust to determine whether care is urgent/immediately necessary? All 30 NHSE trusts responded to the FOI requests. The answers obtained are available in a table appended to this article (see [Appendix 1](#)).

2.3. Analysis

Data derived from the semi-structured interviews and FOI documents

were analysed using thematic analysis. To become familiar with the data, the first author began by closely reading the interviews and FOI documents taking general notes in a research diary on what appeared interesting, unusual and perhaps significant. The material was then coded systematically following a deductive approach ([Braun & Clarke, 2014](#)). Pre-developed codes were generated using existing information on topics identified from the literature review, as well as close readings of the raw data.

The coded data were, first, categorised and linked by relationships into categories. Thereupon, links were established between the categories and defined properties such as phenomena, causal conditions, context, action strategies and consequences. Through an interpretative process, four main themes were identified, including barriers to accessing healthcare, collision between immigration policies and healthcare entitlements, fear generated from discriminatory and exclusionary policies and practices, as well as cultural competency. Additionally, sub-themes included, language barriers and a general lack of knowledge regarding available services for refugees, asylum seekers and undocumented migrants.

2.4. Limitations

The present study has several limitations. Firstly, the study consists of a small sample size that was collected from one charitable organisation. All participants worked in the same role as caseworkers and hence had similar experiences to report in regard to accessing healthcare for refugees, asylum seekers and undocumented migrants in the UK. No refugees, asylum seekers or undocumented migrants were interviewed as part of the study. Therefore, the views and experiences told in the interviews can only tell a partial story as the lived experiences of refugees, asylum seekers and undocumented migrants could not be directly reflected. No NHS employees were interviewed as part of our study either to verify information provided by DOTW caseworkers. However, FOIs and policy documentation substantiated their claims sufficiently. Despite these limitations, the current study provides valuable evidence and insights into the social and political environment surrounding access to healthcare for refugees, asylum seekers and undocumented migrants in the UK, and provides scope for further highly necessary research in this area.

2.5. Ethics

Ethical approval was obtained in advance through the King's College London Research Ethics Committee (Research Ethics Number MR/16/17-1032).

3. Results

In what follows, we present the views of DOTW caseworker volunteers regarding their clients' experiences with access to healthcare. Key themes discussed are the role of legal documentation when registering for healthcare, NHS charging regulations and the associated upfront payments, and other barriers such as language that can act as deterrents in accessing healthcare for refugees, asylum seekers and undocumented migrants. We end by sharing recommendations by caseworkers on how the current situation could be improved to ensure healthcare for displaced populations in England.

3.1. The role of immigration documentation in accessing healthcare

All DOTW health providers participating in this study expressed concerns about how immigration documentation restricts access to healthcare for refugees, asylum seekers and undocumented migrants. Having to provide proof of identification and address upon registration, deterred many from accessing care in the NHS or registering with a GP, due to the fear of being found, detained, and deported by the Home Office. One study participant explained, "You know she [service user] is

scared of being found by the HO. This is the biggest fear that migrants have, they don't want to be deported back to countries where they are even more at risk of harm." These concerns were often voiced in relation to the then newly introduced NHSE Digital Policy, whereby the Home Office received access to online patient records (Gentleman, 2017). Participants reflected on the policy critically stating, for instance, "With the Home Office accessing NHS digital records and people being reported to the Home Office through this to know their whereabouts, this will deter people from any kind of care whether it is primary, secondary or urgent."

Most participants indicated that demands for documentation were regularly made at GP surgeries. Practice managers and frontline staff were especially perceived as likely to ask for ID cards before registering patients at their surgery. This was corroborated by the FOIs we assessed. One Trust stated that their Data Quality Department collects information about patients without NHS numbers every 4 hours to report them to the Overseas Visitors Team (OVT). It was noted that reception staff ask the generic question, "Have you lived in the UK for the last 12 months?" Patients were also asked to provide documents in Accident and Emergency departments to prove their answer, and ward patients were asked about their residency status. A second Trust explained in greater detail that patients accessing care in their Accident and Emergency department are asked if they have been in the country for less than six months, and to specify whether they hold or are entitled to hold (a) a UK or EEA passport or national ID card; (b) a visa that allows them to work, study or reside in the United Kingdom; or (c) none of the above. The Overseas Visitors Team then follows up with an interview to determine whether or not to charge them for their visit at the NHS.

Study participants from DOTW considered the collection of such documentation inappropriate and assumed this practice resulted from receptionists and practice managers being unaware of NHSE guidelines. It was also explained that it is not easy for many refugees, asylum seekers and undocumented migrants to produce identification documents. A study participant explained, "A lot of people do not have their passports or ID cards, especially service users who have been trafficked, through slave labour, or as a domestic slave, or through domestic violence." Participants stated that failure to provide documentation can lead to delays or the inability to register for GP services, which in turn leads to problems accessing healthcare, including secondary care, as such services usually depend on referrals by GPs.

DOTW caseworkers stated that they help mitigate and support vulnerable populations by advocating for their rights and ability to access and register for essential healthcare in situations where they either lack documentation or are afraid to show it. Such advocacy work was considered important by study participants, as refugees, asylum seekers and undocumented migrants risk being turned away from GP surgeries without registration. However, it was explained that this process of negotiating healthcare access, leads to delays in doctors' appointments as patients circulate back and forth between the GP surgery and DOTW, often being denied registration multiple times. A participant said:

Obviously if someone has a pre-existing medical problem that they need care for, there may be a delay in access to services and to treatment. You know there are cases where people try in a number of different surgeries and get refused a number of different times and that delay in access can be quite significant and may deter people from trying to access care.

Consequently, study participants noted that their clients' health was at risk, leading to a worsening of health conditions, further exacerbating existing chronic health conditions, and, in the case of pregnant women, resulting in pregnancy complications. The UK's hostile environment was thus seen to have detrimental and potentially life-threatening effects on the health of refugees, asylum seekers and undocumented migrants.

3.2. Charging regulations and upfront payment

Another concern among DOTW case and clinic support workers related to the impact of charging regulations on accessing and receiving vital secondary healthcare for asylum seekers (this includes refugees with rejected asylum claims) and undocumented migrants. All participants reported that, while secondary care services can be accessed by all, some services may be chargeable if the patient is not a UK citizen or from the EEA. Such services were listed to include clinic and hospital-based services, such as antenatal care, planned operations, services from specialist clinics like cardiology or renal clinics, or rehabilitation services, such as physiotherapy. The FOIs from NHSE Trusts confirmed this. To determine whether care is immediately necessary/urgent or non-urgent, multiple Trusts explained that the Overseas Visitors Teams in clinics and hospitals follow the guidance as specified in the Department of Health Guidance on Implementing the Overseas Visitors Charging Regulations. The clinician looking after the patient is then asked to specify whether the treatment being provided is, in their opinion, 'immediately necessary/urgent or non-urgent'. The respective answer is documented on the 'Request for Advice' form and returned to the Overseas Visitors officer for information. If that treatment is urgently necessary, no upfront payment is requested. Instead, the payment is redeemed after the treatment is provided (see also GOV.UK, 2018).

Other reasons for being exempted from upfront payment is when a patient is deemed particularly vulnerable. The procedure to determine this and related charging regulations was explained by one of the Trusts as follows:

Once a patient has been interviewed, we can assess whether the patient is exempt from charges (...). The Overseas Visitors officer will speak to the nursing team prior to the interview with the patient to identify any relevant issues, including whether patient's treatment falls under any of the exempt from charges categories. Vulnerable patients (for example, victims of human trafficking) are identified by the nursing or clinical staff and referred to the safeguarding nurse who will inform the Overseas Visitors team. Following this, the Overseas Visitors team will make enquiries with the Home Office to identify patient's immigration status, including those whose asylum applications are under process. Enquiries are made using a secure nhs.net email account, in accordance with the Department of Health Guidance.

DOTW case workers believed that, if executed well, such consultations could potentially alleviate stress experienced by patients about payment and will encourage them to seek the care they require. Unfortunately, the ways in which assessments are performed is often not as straightforward as outlined by the FOIs. Participants noted that the OVTs often fail to set up appropriate payment plans, which leads patients to contemplate whether they can afford the service, and whether to delay, or even avoid, seeking healthcare altogether. For example, participants explained that receiving antenatal care can cost around £5-6k for an uncomplicated pregnancy and, in the case of a complicated pregnancy, can cost up to £8-9k in 2017. When unable to meet payment, women tend to receive sub-optimal care and may suffer from avoidable complications during pregnancy and birth.

Another example of the ways in which upfront payment can act as a deterrent was provided by a participant who remembered a telephone conversation with a service user who had just fallen off a ladder and broken their wrist, with a visible bone protruding from their broken wrist. Instead of calling an ambulance, they called the DOTW advice line due to concerns that a hospital visit would mean incurring large sums of money that they did not have, or being reported to the HO. The consequence of such actions, it was explained, can lead to health conditions worsening and ultimately complicated and more specialised, more expensive care.

Apart from inadequate payment plans, participants noted that the OVTs often fail to set up appointments with patients to impart crucial information about charging regulations. When patients are not informed about charging regulations by the OVTs prior to treatment, patients are sent directly to see the secondary care specialist only to incur large bills weeks, if not months, later. We were told:

There are people who are not aware that they are eligible for charges and so they access care as they would do knowing that they need it or they have been referred by their GP and they may end up in hospital, but only later will they find out that they have been charged. Sometimes, many months later a letter comes even though the OVM spoke to them indirectly at the time, but they still didn't know about the charges.

As patients are often unable to pay these hospital bills, participants explained that they acquire large amounts of debt. If these debts are not paid off within a certain period, they are reported to the Home Office by the respective OVTs. This has been shown to negatively affect future asylum applications that a patient might make. One participant confirmed:

The charges will affect any application that they make to the HO and if they haven't paid or still have to pay within three months, they automatically become known to the HO; the hospitals have a duty to tell them. That will affect any application that they make, it won't be put through unless they clear the debt, which for some people is not going to be possible, and so they are always going to be in a state of limbo, it just adds to the stress they already have and they are not able to live a comfortable, secure life.

Charging regulations, participants agreed, result in refugees, asylum seekers and migrants not accessing healthcare altogether due to fears related to the unaffordability of treatment. They stated that such policies further exacerbate pre-existing health problems among refugees, asylum seekers and migrants. Vulnerable and exempt groups, such as victims of trafficking and pregnant women, can be particularly at risk.

3.3. Understanding rights to access to healthcare

Factors, such as lack of understanding among service users regarding how the healthcare system operates for overseas visitors, language barriers, and lack of translators, were believed to present additional barriers to accessing care. Participants observed that although refugees and asylum seekers (including those with ongoing appeals) have the right to free healthcare, they are sometimes not fully aware of their rights and how the UK healthcare system operates. As a consequence, they fail to complain when charging regulations for overseas visitors are applied incorrectly, especially when frontline staff are not aware of the correct protocols and/or patients are not fully aware of their entitlements within the NHS. Consequently, patients may make large payments for free treatment. One participant stated: "Service users often ask, 'how much is it going to be? I don't have any money,' but little do they know that it is all free, so it is just the case of filling them in about the guidelines and their entitlements."

Besides lack of information sharing, participants also highlighted that language barriers are partly to blame for service users' lack of knowledge regarding entitlements. As English is the main language spoken in GP surgeries and Trusts around England, this poses barriers for non-native speakers of English as they try to access services, explain symptoms and ailments, and ask for care. One participant stated: "Language is an issue. So, a lot of migrants or refugees do not know what they are entitled to, cannot communicate their needs, just even problems with trying to register with a GP and explaining/talking to healthcare staff. Language is a big problem for them even when they do register with a GP, interpreters are not available."

While the language barrier could be resolved by using translators

during GP appointments and hospital consultations, it was recognised that there were very few translators available. From the 30 Trusts that took part in the FOIs, only Trust 12 claimed that translators were offered and provided where appropriate. Case workers from DOTW linked the lack of translators and related language barriers to patients missing appointments, treatment delay and negative health implications. One case worker illustrated this with an example of an Afghan service user at DOTW, who had three different GP appointments before an interpreter could be provided and his symptoms could be diagnosed.

To provide adequate support for the service user, the volunteer caseworker team at DOTW had to get NHSE involved, who contacted the GP surgery for them to arrange an interpreting service for the patient. While some service users overcome such barriers by using family members or friends to act as translators, many do not have access to such social networks. To resolve this barrier one participant suggested:

Patients feel more confident about registering at GP surgeries if receptionists and practice managers are of similar ethnic backgrounds or can speak the same language. Having compulsory training for frontline staff will make them more aware and sensitive to cultural associations presented by migrant patients, and lead to them feeling more at ease and not as though they are being judged.

3.4. Recommendations by caseworkers at DOTW

Participants were asked to make recommendations on how access to healthcare and provision of care for refugees, asylum seekers and undocumented migrants could be improved. Most participants stressed that the government and NHS need to, first and foremost, recognise that healthcare is a fundamental human right, and improved healthcare the basis for a better life in a new environment. One participant said:

So, I fundamentally believe that it is a human right to access healthcare and refugees and migrants are in absolutely no way different to that. In fact, they should probably be even more supported in their access to healthcare because of their flight from previous difficult situations. In addition to this, I think individuals have the right to move from areas of war and violence, and so we as a country should be supporting individuals who claim asylum and the right to a better life, but we can only do that if we support them by giving them access to healthcare once they are here.

In order to make health a right, participants highlighted the importance of creating an empathetic health system, which caters to the needs of refugees, asylum seekers and undocumented migrants by recognising the hardships they have faced throughout their journey as a refugee. A participant elaborated:

And then, just having a bit of compassion and empathy in these situations, and I think one of the most concerning aspects of things I hear about interactions with OVTs is the communication and the language they use is very direct and one-track minded on getting the money back and very little regard to someone's situation, be that destitution or, you know, fleeing from whatever situation back home. I mean I don't know if we will ever be able to improve that but DOTW have a real role in highlighting the impact these charges have on individuals.

An empathetic health system involves having meaningful social support structures in place to help refugees, asylum seekers and undocumented migrants to access care without restriction or fear. It was also highlighted that the UK government is aware of these policies and the detrimental effects they have on the populations at hand. Instead, they explained that the underlying problem is that the government does not want to provide care, more specifically free healthcare, to immigrants (documented or undocumented). If populations are not supported in claiming this right, the right itself becomes meaningless.

To counter the uncaring system, participants explained that it is crucial to lobby for policy change, especially in relation to charging regulations and upfront charging. It was explained that if the current healthcare reform situation for migrants continues, it is likely that less and less individuals will access healthcare at the point of need and will end up in emergency care units, in turn exacerbating the current situation of overwhelmed NHS Accident & Emergency departments.

4. Discussion

Our findings suggest that government regulations and Department of Health policies deter refugees, asylum seekers and undocumented migrants from accessing the NHS leading to risky help-and health seeking, lack of or inadequate healthcare, and worse health outcomes among these populations. We argue that such regulations are structurally violent as they prevent refugees, asylum seekers and undocumented migrants from accessing basic healthcare and achieve good health outcomes.

To counter such structural violence and its impact on healthcare access and treatment for displaced populations, DOTW caseworkers called on the UK government to recognise health as a fundamental human right, to develop inclusive social policy and to create an empathetical health system that would allow refugees, asylum seekers and undocumented migrants equitable access to health and social services. They took issue with the current policy landscape, accusing the UK government of purposefully subjecting refugees and asylum seekers to increasingly stringent policies of deterrence. These policies, DOTW workers explained, form a key part of the hostile environment policy against illegal migration (Grierson, 2018; Griffiths & Yeo, 2021; Kirkaldy, 2019; Kronick et al., 2021; Mulvey, 2010; Rawlinson & Gentleman, 2019; Walsh, 2019; Weller & Aldridge, 2019; Weller et al., 2019). Similar arguments have been made by organisations such as DocsNotCops, MedAct and Migrants Organise as part of their “PatientsNotPassports” initiative demanding that healthcare should not be policed (see for instance <https://www.patientsnotpassports.co.uk/learn/key-arguments.html> and <https://www.medact.org/2019/resources/briefings/patients-not-passports/>).

In our study specifically, DOTW caseworkers highlighted that healthcare policing and discriminatory policies deter refugees, asylum seekers and undocumented migrants from accessing vital healthcare and result in detrimental health outcomes. Others have highlighted that this is in stark violation of the WHO Constitution (Burns, 2017). The 1946 Constitution envisions: “The enjoyment of the highest attainable standard of health [as] one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition” (p.1). It is further stated that, “Governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures” (p.1). In line with the WHO Constitution, the UK is legally obliged to ensure access to timely, acceptable and affordable healthcare of appropriate quality and to address the social determinants of health for all (OHCHR, 2008). Health and social policies, in turn, have to prioritise those furthest behind without discrimination on the grounds of race, age, ethnicity or any other status (WHO, 2017). Core components of the right to health include accessibility (i.e., non-discrimination, physical accessibility, economic accessibility, information accessibility); acceptability (i.e., respect for medical ethics, culturally appropriate, and sensitivity to gender); and quality (i.e., health services should be safe, effective, people centred, timely, equitable, integrated, efficient) (WHO, 2017).

Refugees, asylum seekers and undocumented migrants in host Western countries are indicated to be among the most vulnerable and divested groups (Hocking, 2021). However, rather than being prioritised, they are depicted as a burden to the healthcare system (WHO, 2021) and, as our results show, actively excluded from health and social services through structurally violent practices such as discriminatory and racist policies and actions (Burns, 2017). It was clear from both interviews and FOIs that refugees and asylum seekers in the UK do not have unobstructed access to healthcare. Key barriers revealed in our results were legal status

and the inability to provide proof of residence upon registering at GP surgeries. Although producing proof of residence is no longer required, some receptionists and practice managers continue to demand it. This, we assume, can be explained by the fact that guidelines originally designed by the Department of Health in conjunction with the Home Office around this hostile environment, have become so engrained in the minds of practice managers that this poses issues, despite the policy now being revised.

Such structurally violent policies and guidelines unleash discriminatory practices which objectify and ‘other’ migrants. ‘Othering’ can be defined as the ways in which majority and minority groups are socially constructed and how societies establish identity categories (Tanyas, 2016; Torres, 2006; Udah & Singh, 2019). Our results indicate that ‘othering’ in the NHS occurred through document checks, charging for secondary care, inappropriate data sharing and other migration enforcement concerns (similar arguments have been made by Chiarenza et al., 2019; Nellums, Rustage, Hargreaves, Friedland, Miller, & Hiam, 2018; Russell et al., 2019). The underlying reason has been partially linked to health care professionals’ lack of awareness of health care eligibility and entitlements for legally differently positioned refugees and migrants (Tomkow et al., 2019). Consequently, those affected may be incorrectly charged for secondary care and have their healthcare services delayed, which may ultimately lead to worse physical and mental health outcomes (see also BMA, 2021; DOTW, 2018; Nellums, Rustage, Hargreaves, Friedland, Miller, & Hiam, 2018).

We found that access to health services was further hindered by unaffordability. The UK’s charging regulations for secondary healthcare stipulate that asylum seekers with refused asylum claims, and undocumented migrants, may be charged upfront to become eligible for treatment unless the said treatment is considered urgently necessary, in which case refugees are billed afterwards. Another crucial barrier to healthcare highlighted by DOTW workers related to information accessibility. Language barriers and a lack of translators in NHS clinics made communication about health problems and treatment regimens difficult, if not impossible. Such barriers have detrimental health impacts for refugees in numerous Western host country settings. For instance, Hocking (2021) writes that in Australia, refugees indicated that inaccessible and unaffordable healthcare led chronic or minor health conditions to deteriorate over time, requiring more expensive and specialist treatment later on.

Restricting access to healthcare services based on people’s immigration or legal status is discriminatory and dangerous in that it leads to worse health outcomes (Kronick et al., 2021). To mitigate this, there is a clear need to consider more inclusive guidelines that follow a public health approach interwoven with a human rights perspective that challenge the discriminatory structures at play (Meier et al., 2018; Nellums et al., 2018a). Establishing more inclusive migrant healthcare is critical for supporting health as a human right, regardless of immigration status (Chuah et al., 2018; Nellums et al., 2018a; Spitzer et al., 2019). In the short term, this can be achieved by revising policies and guidelines connected to overseas visitor charging and the need for documentation, in order to make healthcare accessible to all (DOTW, 2018; Alex & Vancea, 2016; Martinez et al., 2015; Weller et al., 2019; Zaklaci, 2019).

In the long-term, the UK government must work towards a more empathetic and fairer delivery of healthcare for all by prioritising those furthest behind and most disadvantaged in society. An empathetic health system would require policy makers and service providers to acknowledge, validate and address the precarious situation and needs of refugees, asylum seekers and undocumented migrants (Jeffrey, 2016; Stone, 2019). Concretely, this requires, first and foremost, tackling underlying causes of ill health including discriminatory policies, racism, and exclusion; addressing the social and economic determinants of health; and providing meaningful and culturally sensitive healthcare and social support. Based on findings from our literature review and empirical research, we argue that improving healthcare for refugees, asylum seekers and undocumented migrants must rest on four pillars: (1) the understanding that tackling social determinants requires a political more

than a clinical response; (2) the response needs to be intersectoral whereby health can only be improved through strong partnerships and cooperation across sectors such as welfare, housing, education and employment; (3) the cooperation between these sectors has to be built on solidarity where organisations are willing to give resources because they understand that they work toward a common goal – namely, improved quality of life and health for refugees; and (4) the generation of best practice evidence as part of the interventions so that their effectiveness can be tested in changing contexts and based on changing demands (Kienzler, 2019). We are convinced that investing in such a fair and intersectoral approach will not only benefit refugees, asylum seekers and undocumented migrants, but everyone in society as it has the potential to address social inequalities that have been widely shown to detrimentally affect people's health and wellbeing.

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Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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Appendix A. Supplementary data

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