UK COVID 19 INQUIRY: MODULE 4

OPENING SUBMISSIONS ON BEHALF OF THE MIGRANT PRIMARY CARE ACCESS GROUP ('MPCAG') FOR HEARINGS 14 to 31 JANUARY 2025

Introduction

1. For the purpose of participation in Module 4 of the UK Covid-19 Public Inquiry, Doctors of the World ('DOTWUK'), The Joint Council for the Welfare of Immigrants ('JCWI'), Kanlungan Filipino Consortium, and Medact have formed a collective known as the Migrant Primary Care Access Group ('MPCAG'). During the pandemic, MPCAG member organisations emerged as prominent experts on the health consequences of Covid-19 for migrants in the UK in light of the vital work and support they provided to migrant communities. Their evidence in Module 4 identifies the barriers and inequalities that prevented access to the Covid-19 vaccine and therapeutics for a significant proportion of the migrant community.

2. Central to the Inquiry's task of assessing the effectiveness of the Government's actions to facilitate equitable access to vaccines and therapeutics is the incontrovertible principle that the success of such measures, intended to protect public health at its widest, hinges entirely on achieving widespread and inclusive vaccine uptake. The failure to address extant and persistent barriers that exclude certain segments of society based on their migration status not only exacerbates those inequalities but also undermines the health and safety of the entire population, as well as the overall aims of maintaining and ensuring public health.

3. MPCAG represent people from various migrant communities across the UK, a group known to have a higher mortality rate from infectious disease, and lower general vaccine uptake compared with the wider population. Migrants have consistently been recognised as an 'Inclusion Health Group', a demographic characterised by social exclusion and a convergence of multiple risk factors that adversely impact health outcomes, including poverty, violence, and complex trauma. Many migrants occupy an intersectional space as being both Black, Asian, and Minority Ethnic (BAME) individuals and amongst the most socio-economically deprived. For both of these groups, the data consistently highlights a higher risk of exposure to and of death from Covid-19, and disproportionately lower vaccine uptake. Despite this, the evidence before the Inquiry demonstrates that during the Covid-19 pandemic the Government persistently failed to address the fundamental question necessary to design and implement effective interventions aimed at ensuring equitable access to vaccines and therapeutics for this population – namely, *what were the root causes of the barriers to vaccine and therapeutics experienced by migrants?*

4. Kastaan-Dabush and Chantler in their expert report for Module 4 on Vaccine Delivery and Disparities in Coverage have identified that national policy, particularly immigration policy, had an adverse impact on vaccine delivery strategies during the pandemic. This finding reinforces MPCAG'S central position advanced to this Inquiry.

5. MPCAG's opening submissions address failures in the vaccine delivery model, inadequate Home Office and Department of Health and Social Care ('DHSC') intervention, and the impact of a restrictive approach taken by Government to health inequalities and vaccine uptake. Overarching this is the Government's failure to identify and dismantle Hostile Environment immigration healthcare policies that deterred and prevented migrant access to healthcare, including life-saving vaccines and therapeutics, during the pandemic.

6. The term 'Hostile Environment' encompasses a raft of policies that impose stringent socio-economic and healthcare exclusions on certain migrants as a form of immigration control. Two elements of the Hostile Environment framework had a particularly pernicious effect in the context of a national public health emergency:

7. **First**, a significant barrier to access to the Covid-19 vaccine and therapeutics was the NHS charging regime that imposes charges on individuals not ordinarily resident in the UK. Under this regime, people who are not deemed to be ordinarily resident are either refused treatment, and/or made subject to debt collection action for services received charged at a punitive rate of 150% of the cost to the NHS of said treatment (i.e., inclusive of a 50% fine). Although the hostile environment policy agenda and overarching legislation (i.e. the Immigration Acts 2014 and 2016) was introduced by the Home Office, the NHS charging regime now sits squarely within the remit of the DHSC, which has laid Regulations underpinning the Charging regime and is responsible for its operation.[1] Key elements of the Charging Regulations remained fully operational throughout the pandemic. These included the Regulations that mandate the NHS to undertake immigration checks with the Home Office, either to grant individuals access to non-urgent paid-for treatment, or to pursue charges for emergency treatment and report unpaid debt directly to the Home Office. This regime has instilled deep-rooted fear and mistrust in certain migrant communities, a phenomenon that was well known and well documented before the onset of the pandemic.

8. **Second**, the evidence shows that there is entrenched fear amongst migrant communities of data-sharing between the NHS and Home Office (which, after all, was the intention of the Home Office), that deterred and prevented access to the vaccine and was not properly addressed. Belated assurances that accessing the vaccine would not result in immigration checks did not amount to a guarantee that data would not be shared with the Home Office. Indeed, no such assurances could accurately be provided. This would only have been possible had the mandatory data-sharing requirements under the NHS Charging Regulations been suspended or revoked, which was *not* the case. At no stage did the Government implement a data-sharing firewall between the NHS and the Home Office. The ongoing operation of the NHS Charging Regulations throughout the pandemic meant that mandatory immigration checks and debt collection mechanisms between the NHS and the Home Office persisted for long Covid and non-Covid related treatment.

[1] DHSC introduced two sets of regulations: The National Health Service (Charges to Overseas Visitors) Regulations 2015 and The National Health Service (Charges to Overseas Visitors) (Amendment) Regulations 2017

9. Not a single witness from among the key decision-makers in the central Government departments of DHSC (The Rt Hon Matt Hancock, The Rt Hon Sir Sajid Javid, Clara Swinson), the Home Office (Antony Eastaugh), or in any other relevant Government minister or department (The Rt Hon Kemi Badenoch, The Rt Hon Nadhim Zahawi), has identified or referred to, either by name or in substance, the NHS Charging regime or NHS data-sharing, or addressed their impact on migrant access to healthcare and life saving clinical measures during the Covid-19 national health emergency.

10. This wholesale Government-wide omission is stark. Failure to acknowledge or even consider this root cause of low uptake amongst migrants obviously meant that barriers to access could not be, and were not, mitigated or removed.

11. *At best* this failure to identify and address the impact of persisting and exclusionary Hostile Environment immigration healthcare policies on access to vaccines and therapeutics reveals an institutionally blinkered approach to assessing individualised risk and barriers faced by vulnerable cohorts. *At worst* it amounts to a wilful reluctance to prioritise wider public health over immigration control, even during the most harrowing national health emergency experienced for decades - with clearly identifiable consequences. It is notable in this regard that the only reference to advice sought by the Home Secretary in relation to vaccine access for migrants was to consider limiting local authorities' ability to apply flexibility towards asylum seekers when implementing the JCVI guidance due to concerns that this might attract negative press.[2] This reveals the preoccupation of the Government with immigration, which undoubtedly drove their approach to these policies.

12. The failure to properly identify and address systemic barriers to migrant healthcare access had serious and sometimes fatal consequences for this cohort. It is deserving of criticism from the Inquiry commensurate with the harm and the risk of harm it caused. If maintained, this approach will continue to cause such harm during the next public health emergency or pandemic the UK faces. It necessitates robust recommendations from the Inquiry that restate the priority of public health over immigration policy and the imperative to reverse the encroachment of immigration policies into the domain of the universality of primary healthcare and access to it. The UK Government must now take this opportunity to work across departments and ensure that access is in place for all.

UK context when Covid-19 struck

13. The disproportionate impact of Covid-19 on vulnerable groups who were already disadvantaged, exacerbating pre-existing socio-economic and health inequalities, is fully acknowledged by the Chair to the Inquiry: *"The impact of the disease did not fall equally. ...People from some ethnic minority groups and those living in deprived areas had a significantly higher risk of being infected by Covid-19 and dying from it."*[3]

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[2] INQ000474422 – Witness statement of Antony Robert Eastaugh CBE, 7 November 2024 [at § 139-140 and exhibit INQ000398359] and [§ 146 and exhibit INQ000054755]

[3] UK Covid-19 Inquiry, Module 1: The resilience and preparedness of the United Kingdom. A report by The Rt Hon the Baroness Hallett DBE Chair of the UK Covid-19 Inquiry, July 2024. Page viii.

14. Specific to migrants, the policy context and backdrop against which the Covid-19 pandemic struck is critical to understanding the deep-rooted and mounting sense of fear, mistrust, threat and ostracisation caused or perpetrated by Government bodies and politicians over decades, that significantly heightened the risks they faced:

    i. For the past 50 years, since the 1970's, respective governments have introduced increasingly draconian measures, known collectively as the Hostile Environment. These policies sought to exclude, criminalise, impoverish, and threaten undocumented migrants in the UK, with the ultimate stated aim of compelling them to leave the country. However, they also impact a significant proportion of other migrants in the UK with precarious immigration status - whether directly or indirectly. These policies require landlords, employers, and even healthcare providers to check immigration status, effectively deputising them as immigration enforcers. These policies have purposefully encroached into areas such as health to control and prevent access to secondary healthcare through the NHS Charging regime and data-sharing practices; to social welfare through to the No Recourse to Public Funds (NRPF) condition which excludes most migrants from the social welfare safety net; to private landlords and estate agents to prevent access to privately rented accommodation; to the DVLA to prevent access to a driving licence; to private banks to prevent access to bank accounts, and to the labour market through employment prohibitions and Right to Work checks.

    ii. For over two decades, there has been a consistent and repeated disregard of previous official findings of racial inequality. Since the 1999 Macpherson Report into the death of Stephen Lawrence, there have been 10 major government reports and reviews that collectively have made a total of 375 recommendations to address racism and inequality, most of which remain outstanding. This sends a strong message to minority ethnic communities that racial equality is not any government's priority.

    iii. From 2010, a decade of austerity measures in the form of deep cuts to public spending, significantly widened health inequalities.

    iv. In 2013, the Home Office infamously commissioned vans bearing the slogan "Go Home" to drive around areas known to have a high migrant population.

    v. In 2014 and 2016 the introduction of the key aspects of the Hostile Environment by legislation in the Immigration Act 2014 and Immigration Act 2016

    vi. In 2016, immigration was a central issue surrounding the Brexit vote.

15. Over the past decade, health inequalities in England have significantly widened. The Office for National Statistics (ONS) has documented persistent health disparities linked to

socio-economic status that reveal individuals in lower socio-economic groups experience higher rates of morbidity and mortality compared to more affluent groups.

16. When the Covid-19 pandemic started, migrant communities were already grappling with profound disadvantages, exacerbated by political antagonism towards migrants, increased deprivation and social marginalisation, restricted access to healthcare, and an omnipresent climate of fear and mistrust. The Government was fully aware of this acute vulnerability among certain migrant groups, as these conditions were deliberately constructed and perpetuated through its *own* policies.

17. In 2020, Wendy Williams published the *Windrush Lessons Learned Review*, tracing the origins of the Windrush scandal to successive iterations of restrictive immigration and nationality policies and legislation, dating back to the 1960s. The review highlighted how ministers and Home Office officials implemented these policies without adequately scrutinising their unintended consequences—a pattern of failed oversight that has proven equally relevant in the context of immigration and healthcare policies, which contributed to low vaccine uptake amongst marginalised migrant communities during the Covid-19 pandemic. Yet, the most pressing lesson from the Windrush scandal remains unaddressed:

> *'This report makes 30 recommendations for change and improvement which can be distilled into three core principles: the Home Office must acknowledge the wrongs that have been done; it must subject itself to greater external scrutiny; and it must transform its culture to recognise that migration and wider Home Office policy is about people and, regardless of its objectives, should be anchored in humanity.'*[4]

18. When considered in this context of entrenched structural racism, pernicious anti-migrant rhetoric and xenophobia, and decades of increasingly draconian Hostile Environment immigration policies designed to exclude, impoverish and demonise migrants, it ought to have been abundantly clear that barriers faced by migrants that prevented or deterred engagement with government institutions, and in particular healthcare services, could not be simply or easily dismantled by a mere communication and outreach strategy. This narrow focus on communication, which was the limit of the Government's efforts, was manifestly misguided. Ultimately therefore any locally led outreach work was inadequate.

19. The Covid-19 Inquiry now stands at a critical juncture, having the power to make robust, impactful recommendations as to how to dismantle barriers and break the entrenched cycle of deprivation and disadvantage in access to healthcare perpetuated by immigration policies. This is the only way to ensure a renewed commitment to a humane approach towards migrants, consistent with the paramount objective of putting public health first.

Inadequacies of the vaccine and therapeutic programme for migrants

20. Despite the Government's evidence of limited efforts undertaken during the pandemic to engage BAME and, to a lesser degree, migrant communities through various initiatives,

[4] *Windrush Lessons Learned Review, Independent review* by Wendy Williams, Ordered by the House of Commons, 19 March 2020, p.7

the following analysis highlights the main ways in which these initiatives fell short. Whilst it is acknowledged that *some* measures were implemented, MPCAG maintains that these were either delayed, superficial, or overly generic and not specific to the needs of migrants and the unique barriers to vaccine uptake in the context of denial of access to healthcare. Any such efforts ultimately failed to address the systemic and root cause of those barriers acutely experienced by migrants to accessing vaccines and therapeutics.

21. Consequently, the main migrant barriers to healthcare (including vaccines and therapeutics) remained firmly in place and the overall impact of peripheral interventions was extremely limited. Any such efforts failed to achieve their objective of equitable access to vaccines *for the entire population* for the benefit of wider public health.

NHS Charging Regime – immigration control prioritised over public health

22. As detailed above, the DHSC's NHS Charging Regulations remained operational *throughout* the pandemic. They were neither suspended nor repealed, either of which would have helped to ensure certainty and build critical trust amongst migrants that they could have unimpeded access to healthcare services. At no stage were those *mandatory* requirements under the Charging regime relating to routine data-sharing between the NHS and the Home Office suspended. No data-sharing firewall was implemented. This meant that the most significant and harmful barriers to healthcare access for certain migrants remained firmly in place.

23. In relation to ensuring free access to Covid-19 vaccines and therapeutics for migrants once the pandemic had begun, the Government did nothing more than the bare minimum.

24. On 29 January 2020, Covid-19 was designated an exempt communicable disease under the *National Health Service (Charges to Overseas Visitors) Regulations 2015*, to ensure that overseas visitors, including those living in the UK without permission, would not be charged for narrowly defined Covid-19-related services. To date, and throughout, charges continue to apply to treatment for long-Covid or other health complications caused by Covid, unless any of the highly complex exemptions apply.[5] Therefore seeking treatment for Covid-19, without control or foresight as to whether longer-term or other health complications will also require treatment, continued to carry a very real risk for migrants of either being denied treatment if unable to pay upfront inflated charges and/or being subsequently pursued for unpaid charges with potential immigration consequences. The uncertainty as to whether charges would be applied was amplified in circumstances involving a novel virus for which the symptoms were unknown and/or emerging. This risk applied to undocumented migrants and those with precarious immigration status as a result

[5] By way of amendment to Schedule 1 (*diseases for which no charge is to be made for treatment*) of the National Health Services (Charges to Overseas Visitors) Regulations 2015/23 by inserting "*Wuhan novel coronavirus (2019-nCoV)*" from 29 January 2020 by Regulation 2 of the National Health Service (Charges to Overseas Visitors) (Amendment) Regulations 2020/59. The wording was later amended to *"Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2)*"

of the extraordinarily complex Charging Regulations, which were also frequently erroneously applied by NHS staff.[6]

25. Data-sharing practices between the NHS, the DHSC, and Home Office unequivocally deter migrants, particularly undocumented migrants or those with precarious immigration status or who perceive their status to be precarious, from accessing healthcare services. This is rooted in a fear of having to share their personal information with healthcare workers, that in turn may be shared with immigration enforcement officials.[7] The Witness Statement of Antony Eastaugh on behalf of the Home Office refers only to data-sharing practices pursuant to a former Memorandum of Understanding ending in 2018.[8] Whilst this is correct, this was only one channel through which data was shared. Routine and *mandatory* data-sharing takes place between all NHS Trusts and the Home Office pursuant to the Charging Regulations. Healthcare workers contact the Home Office to verify immigration status to identify liability to pay up front or be pursued for healthcare charges. NHS Trusts must inform the Home Office of unpaid healthcare debt, which may result in immigration consequences. These routine data-sharing practices remained fully operational throughout the pandemic.

26. At no stage during the pandemic was a data-sharing firewall implemented between the NHS and the Home Office to allay fears of immigration enforcement action. Belated assurances that immigration checks would not be undertaken when accessing a vaccine were insufficient as they did not amount to a guarantee that information would not be shared with the Home Office. This served to fuel mistrust by migrants of the NHS and fear of accessing NHS services including primary care.

27. A paper from UKHSA formed the basis of recommendations made by PHE to JCVI on Inclusion Health Groups.[9] Critically, it identified the same issues and barriers that MPCAG have repeatedly raised:

> "*Emergency legislation was introduced in early 2020 to include COVID-19 on the list of infectious diseases exempt from charging when accessed via the NHS [30]. This ensured testing and treatment for COVID-19 was free of charge irrespective of immigration status. However, there is qualitative evidence that providers' limited awareness of entitlements to NHS services and vulnerable migrants' fear of charging for use of NHS services, lack of trust in statutory bodies and data sharing with the Home Office delays and deters presentation to care [31, 32]. Misleading assurances in relation to NHS and Home Office data sharing practices.*"

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[6] 'Undocumented' refers to those with no lawful leave to enter or remain in the UK. 'Precarious immigration status' refers to any immigration status that is not Indefinite Leave to Remain (see, Supreme Court judgment in *R (Rhuppiah) v SSHD* [2019] 1 All ER 1007).

[7] Where an applicant has any outstanding charges to the NHS of over £500 for over two months this may be reported to the Home Office (*NHS Costs Recovery Overseas Visitors Guidance*) and any such outstanding debt may be a ground for refusal, see Immigration Rule 9.11.1

[8] INQ000474422 – Witness statement of Antony Robert Eastaugh CBE, 7 November 2024, para 69.

[9] INQ000477084 – Paper from UKHSA, titled Covid-19 vaccination in inclusion Health Populations, dated 20/01/2021 at page 4.

28. In March 2021 the Head of Priority Campaigns at the DHSC sought advice from the Home Office on communicating with undocumented migrants. Concern was raised that the NHS Charging Regulations and data-sharing policies were causing distrust and impacting the DHSC's efficacy of public health messaging on vaccines to migrant communities.[10]

29. The Behavioural Science and Insight Unit at PHE also produced a paper during the pandemic assessing the barriers to vaccine uptake in various communities.[11] In respect of migrant communities, the following barriers were identified:

> *"Concern that accessing health services will impact on migration status, for example due to data being shared with immigration services (Deal et al., 2021; Kanlungan, 2020; Nazroo et al., 2020; Nellums et al., Liaison 2018; Tankwachi et al., 2020)"*

30. It is clear that from the early stages of the pandemic, the Home Office had access to evidence from public health experts that maintaining the NHS charging and data-sharing systems would prevent people from coming forward for treatment and vaccination for Covid-19. That the charging and data-sharing regime were maintained indicates an *active* choice to prioritise immigration policy objectives over wider public health and expert scientific public health advice.

Lack of proper process to protect migrants whose leave expired during the pandemic

31. If an individual remains in the UK *after* their leave to enter or remain has expired, they are in breach of immigration laws and face the full force of Hostile Environment policies and are liable to be detained and removed. Due to lockdowns and travel restrictions, migrants whose leave expired during the pandemic were unable to leave the UK when their visas expired.

32. The Home Office's 'Exceptional Assurance Concession scheme', introduced on 1 September 2020, represented a wholly inadequate and piecemeal response. Not only did it fail to afford affected migrants with an enforceable statutory right under the Immigration Rules or confer any leave to remain to ensure certainty and protection, it also strongly echoed the findings of Wendy Williams that ministers and Home Office officials implement policies without adequately scrutinising their *"unintended consequences"*. The interaction of this scheme with the NHS Charging regime (that remained fully operational, with limited and complex exemptions for Covid treatment), during a time when access to healthcare had never been more important, was overlooked.

33. MCPAG were aware of uncertainty within migrant communities over whether the Exceptional Assurance scheme extended access to NHS services without charges, i.e. an extension of an individual's pre-paid Immigration Health Surcharge that exempts them from NHS charging. There was a similar lack of clarity or understanding within the NHS and staff. No amendment was made to the Charging Regulations to include this cohort,

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[10] INQ000398362 - Email chain between DHSC and Home Office officials, regarding Vulnerable/undocumented migrants, dated 01/03/2021 to 02/03/2021

[11] INQ000477100 - Paper from PHE BSIU titled Vaccine uptake communities summaries, undated.

and similarly no amendments were made to the 'Charging guidance for NHS staff' to identify or refer to the position of this cohort. Hence it is clear that there was no intention by the Government to attempt to address and include such migrants within access to non-emergency healthcare during the pandemic.

34. It is apparent that this uncertainty arose because NHS Charges are imposed by the NHS with DHSC oversight, rather than by the Home Office. As a matter of statutory obligation, the applicable Charging Regulations do not give the Home Office (nor the NHS) any general discretion to waive a person's liability to NHS charges. Therefore, the exceptional immigration status-related assurances given by the Home Office were not directly enforceable or applicable to the NHS Trusts applying the Charging Regulations in practice. This is a clear example of a lack of joined up thinking which maintained the harmful consequences of immigration healthcare policies.

Vaccine booking system built on an exclusionary model

35. Prior to the pandemic, it was well documented and well known by the Government that certain migrants faced barriers to accessing primary care and were routinely wrongly refused GP registration. This resulted in certain migrants, and other Inclusion Health Groups, not having an NHS number and not appearing in primary healthcare records.

36. During the two stages of the vaccine roll out migrants were excluded from both processes in different ways. This exclusion exacerbated existing health inequalities and increased the risk of morbidity and mortality for this cohort.

37. In the early stages of the vaccine rollout, primary care medical records were they key source used to identify and invite eligible individuals for vaccine based on JCVI's risk assessment. This model required individuals to have an active GP registration. The Government had full awareness that this approach to early vaccine delivery for extremely clinically vulnerable individuals directly excluded certain migrants (and other Health Inclusion Groups) who were known not to feature in primary care records.

38. In the next phase, the National Booking System, the gateway platform implemented to identify and invite the general population for vaccination once they became eligible based on JCVI's risk assessment, required individuals to have an NHS number *and* an active GP registration. The Government had full awareness that this platform directly excluded certain migrants (and other Health Inclusion Groups) for the same reason.

39. It took the Government more than a year after the onset of the pandemic, and several months following the initial rollout of the Covid-19 vaccination, to issue formal guidance stating that individuals did not need an NHS number or GP registration to receive the vaccine and should not be denied access on this basis. This action was too little, too late for the most at-risk elderly or clinically vulnerable migrants who would have been overlooked for a vaccine invitation at a critical stage of the roll-out and/or faced an administrative barrier to booking a vaccine in any event.

40. Although the Government eventually sought to address this issue by allowing vaccines to be administered without an NHS number and establishing walk-in and pop-up vaccination centres, these efforts were insufficiently publicised and came too late to effectively mitigate the barriers faced by migrant communities. The lack of robust communication strategies left many migrants unaware of these provisions or sceptical of their applicability, having already been directly or indirectly excluded from the mainstream healthcare system. Furthermore, it did not remedy the procedural barrier imposed by the booking system. At all times, and to date, the National Booking System requires as a pre-requisite an NHS number to pre-book a vaccine appointment. It is for this reason that many migrant NGOs, including MPCAG, were required to fill in the gaps and set up their own vaccine clinics.

Overly wide and generic focus on BAME communities

41. The Government identified early in the pandemic that there was a link between ethnicity and higher mortality rates. Numerous studies confirmed that individuals from BAME backgrounds faced significantly higher rates of infection, hospitalisation, and mortality during the pandemic compared to their white counterparts. In response, the Prime Minister tasked the Race Disparity Unit and the Minister for Equalities with leading a cross-government effort to address these disparities. The Government commissioned several Race Disparity Reports, providing an analysis of the health inequalities experienced by ethnic minorities during the pandemic. These reports highlighted the disproportionate impact of Covid-19 on these communities and underscored systemic issues affecting healthcare accessibility. However, they failed to properly address the specific issues concerning migrants as a discrete group or sub-set within that.

42. Throughout the pandemic PHE/UKHSA and JCVI produced varied and detailed evidence on the need for tailored approaches for different Inclusion Health Groups, including migrants. There was repeated advice that broad-brush categories were not sufficiently nuanced to address vaccine inequity, including by behavioural scientists from Oxford University in March 2021 who cautioned:

> *…it is important to move beyond broad categories, such as age or ethnicity, to examine the intersectional and cumulative effects of low vaccine uptake. There is cumulative low uptake compounded in certain groups…*[12]

43. Instead, they proposed that they:

> *"...**move beyond broad sledgehammer categories of age and ethnicity to nuanced sub-groups that properly control for confounders and recognise intersectionality of stratified traits that result in cumulative disadvantage in order to be more effective and avoid stigmatising groups…"***

[12] INQ000111706 - Paper from DHSC, titled SPI-B: Behavioural considerations for vaccine uptake in Phase 2 and beyond, introduction and executive summary, dated 09/03/2021.

44. Despite this advice and the available 'Inclusion Health' framework offering an alternative to traditional equalities categories, the Government continued to approach vaccine equity in this way. This approach was particularly harmful for migrant communities. For those within the BAME communities who are also *migrants*, these identified risk factors are compounded by the *additional* vulnerabilities associated with precarious immigration status, language barriers, and exclusion from social services and social welfare support. The convergence of these vulnerabilities created a perfect storm in which BAME migrants are disproportionately exposed to and affected by Covid-19 while simultaneously facing greater obstacles in accessing healthcare and support due to immigration healthcare policies and practices.

Communication strategies were erroneously considered a panacea for all groups

45. It is clear on any analysis of Government initiatives to increase vaccine uptake that the focus was almost exclusively on communication and outreach work. Whilst this may have been effective for those who fall neatly under the umbrella term of "vaccine hesitant", the structural and systemic healthcare barriers imposed by Government via immigration healthcare policies cause the situation of migrants to fall outside this definition. As such, mere communication strategies could never contend with or mitigate the powerful long-standing embedded barriers experienced by migrants. These strategies were either fundamentally flawed from the outset, because they failed to identify and dismantle the root cause of migrant-specific barriers to vaccines, or were never intended to be tailored to the needs of migrants and reflected a more generalised intervention that overlooked migrants.

46. The Government's communication strategy largely conflated BAME communities with migrants, assuming that measures to target BAME groups would automatically encompass migrant-specific needs. The messaging sought to encourage communities to take up the vaccine, whilst ignoring the root causes of people's fear, particularly for those afraid to take up the vaccine on account of their immigration status. This approach neglected the unique socio-legal, linguistic, and cultural barriers faced by migrants (imposed by Hostile Environment policies) which included fears of immigration enforcement, lack of awareness about NHS entitlements, and limited access to translated information. Migrants, including refugees, asylum seekers, and undocumented individuals, often experience healthcare inequities unrelated to ethnicity but tied to immigration status, employment precarity, and housing instability.

47. Although the Government partnered with mainstream faith groups and ethnic minority organisations, they did not adequately engage grassroots migrant advocacy groups, charities, or diaspora networks. Community leaders from migrant groups were unsupported and largely left to navigate supporting their communities without guidance, further isolating migrant communities from government bodies and missing an opportunity to leverage their trust and influence to combat misinformation and distrust of the Government, and encourage vaccine uptake.

48. The Government's communication efforts were found to be inadequate to counter Hostile Environment barriers when assessed in June 2020 by Medact, Migrants Organise and the New Economics Foundation.[13] The research highlighted several important factors which undermine the Government's communication efforts. While treatment for coronavirus and other communicable diseases was exempt from NHS charging, only 20% of respondents agreed that migrants were aware of this exemption. 56% of respondents had not seen any information from public bodies raising awareness of migrants' rights to healthcare during the coronavirus crisis. Only 9% of respondents thought that information about Covid-19 being exempt from NHS charging was reaching all sections of their communities in an accessible format.

49. Any Government effort to translate critical healthcare information was severely delayed, which served to exacerbate the social exclusion and mistrust experienced by migrants. The Prime Minister's regular press conferences were held in English only, without translation facilities to enable those with limited or no understanding of English to access vital and time-sensitive information. Official guidance on Covid-19 vaccines, including eligibility, safety, and locations of vaccination centres, was translated initially into only 9 languages, eventually reaching 15 languages. It was not until the *end of the 2021* vaccine campaign that the Government had managed to translate information into 26 languages.

Overly narrow focus on 'vaccine hesitancy' and the WHOs 3 Cs

50. MPCAG believe the term "vaccine hesitancy" oversimplifies a complex issue, placing undue emphasis on individual attitudes while obscuring the systemic barriers that often underlie low vaccine uptake among marginalised communities, including migrants. To truly address inequities, public health discourse and policy must move beyond "hesitancy" and focus on dismantling these structural barriers that directly inhibit equitable access to vaccines. By reframing the issue in terms of institutional and state responsibility rather than individual behaviour, the UK Government could have better addressed the root causes of inequities and built an inclusive, accessible vaccination program.

51. Similarly, the Government's overreliance on the World Health Organisation's 3 Cs framework was problematic when attempting to gain a deeper understanding of the systemic barriers to the vaccine and therapeutics faced by migrants. Whilst it may be a useful heuristic for understanding general 'vaccine hesitancy' it does not offer a complete picture of the reasons certain communities have lower rates of vaccine uptake.

52. Migrants, particularly those with precarious immigration status, were often not complacent about the risks of Covid-19. In fact, many lived and worked in high-exposure settings such as healthcare, sanitation, transportation, and food supply, making them acutely aware of the risks. Their fears were not rooted in underestimating the threat but rather in fears of how engaging with healthcare systems might jeopardise their legal status (e.g., data-sharing between health services and immigration authorities). A lack of confidence was not necessarily linked to concerns about the safety of the vaccine, but rather tied to

[13] Patients not Passports, Migrants Access to Healthcare During the Coronavirus Crisis, June 2020

systemic fear and distrust arising from negative interactions with public authorities in the UK or in their countries of origin.

53. In relation to convenience, whilst migrant populations may have experienced some logistical barriers such as distance and accessing transport, the main issues for migrants were more complex. Other factors such as the ongoing healthcare charging mechanisms that were directly linked to the Home Office, an inability to obtain an NHS number to enable a vaccine booking and a lack of awareness or clarity as to the scope of Covid-19 exemption in an already complex charging system fed into the reasons why so many migrants were fearful of coming forward for the vaccine. In addition, social exclusion exacerbated by poor communication about healthcare entitlements and a lack of vaccine information in diverse languages and accessible formats, compounded with anti-migrant sentiment in the UK fostered and fomented by the Hostile Environment, further heightened fear and mistrust.

54. MPCAG consider that the framework used by the Government to increase vaccine uptake, namely the WHOs 3Cs and the concept of "vaccine hesitancy", was overly narrow and fundamentally flawed for migrants who do not fit this paradigm. 'Group think' in adopting this framework for all vaccine uptake action caused proper risk assessment and analysis of barriers specific to certain cohorts, such as migrants, to be ignored and/or overlooked.

55. In March 2021, PHE designed a 'social-ecological action framework for factors influencing vaccine uptake' (not adopted by the Government) which offers a more detailed and intersectional approach to understanding and addressing barriers to vaccine uptake.[14] An approach like this addresses the root causes of barriers, rather than short-term reactive responses engendered under the '3 C's' framework which address the consequences rather than the causes of vaccine hesitancy and spawn short-term and limited interventions such as the Community Champions scheme.

Recommendations and conclusion

56. MPCAG fully endorses the Chair's approach to recommendations: *"Unless the lessons are learned, and fundamental change is implemented, that effort and cost will have been in vain when it comes to the next pandemic..... There must be radical reform."*[15]

57. Thus, MPCAG invite the Inquiry to make bold and impactful overarching recommendations in response to the concerns raised. These include first and foremost ending Hostile Environment policies and overhauling the existing system that devalues the health of migrants, exposes them to harm, and increases the overall public health risk posed by a future pandemic.

[14] INQ000354479 - Report from Public Health England titled National Immunisation Programme: health equity audit, dated 02/2021.
[15] UK Covid-19 Inquiry, Module 1: The resilience and preparedness of the United Kingdom. A report by The Rt Hon the Baroness Hallett DBE Chair of the UK Covid-19 Inquiry, July 2024. Page ix.

58. The UKHSA warned in their report on Covid Vaccine Inclusion Health Populations dated 20 January 2021, that '*ensuring that coverage is not only high overall, but also within underserved communities is ...essential for disease control and elimination strategies.*'[16] There is a fundamental public health need to ensure *all people living in the UK*, regardless of immigration status, can effectively access all levels of health services without fear or threat of punitive action in the form of immigration enforcement or refused healthcare treatment based on ability to pay or fear of debt collection. This is the only way to guard against and remove barriers to public health clinical measures *when*, *not if,* the next pandemic strikes in the 'near to medium future'.

59. MPCAG considers previous endeavours to review or reshape Hostile Environment policies to have been ineffective in engendering any meaningful change in relation to access to primary healthcare, and as such considers that anything less than a clear and measurable recommendation to revoke the healthcare Hostile Environment policies would be futile in combating any future pandemic in public health terms.

60. Consistent with the purpose of the largest public funded statutory inquiry that has ever taken place in the UK, there must be independent oversight of the actions of state bodies, examination of the culture and obstacles to efficacy and identification of where accountability lies, and implementation of structural changes and avoid repetition of failures.

61. In 2020, the Windrush Inquiry similarly recommended a comprehensive review of Hostile Environment policies—a call that, to date, has failed to yield any meaningful reform.[17] MPCAG regards the UK Covid-19 Inquiry as an essential opportunity to undertake that overdue review. The Inquiry is now presented with substantial evidence demonstrating the significant barriers migrants face in accessing life-saving vaccines and treatments – barriers that are entrenched in Hostile Environment policies. Moreover, the absence of any reference to these policies within the evidence of key decision-makers underscores a persistent lack of Governmental acknowledgment of or effort to dismantle these systemic obstacles. It is critical that this Inquiry issues an unequivocal recommendation for radical and transformative change without delay to achieve effective public health measures that are accessible for all.

62. The specific recommendations sought are as follows:

    i. Public health policy must <u>always</u> be prioritised over immigration policy;

    ii. To that end 'Hostile Environment' policies must be removed. Most urgently and principally, this includes the NHS charging regime and data-sharing between the NHS and Home Office which must without delay be permanently discontinued;

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[16] INQ0004 77084 - Paper from UKHSA, titled Covid-19 vaccination in inclusion Health Populations, dated 20/01/2021.

[17] *Windrush Lessons Learned Review, Independent review* by Wendy Williams, Ordered by the House of Commons, 19 March 2020, Recommendation 7, p.141

iii. There must be a permanent data-sharing firewall between healthcare services and the Home Office- without this, trust cannot be built or maintained;

iv. GP surgeries, hospitals, and vaccine centres must be designated as 'safe spaces' where immigration enforcement action is prohibited;

v. All barriers to accessing primary healthcare and registering with a GP must be removed. The Home Office must amend its Statement of Requirements with Asylum Accommodation providers to ensure that support is provided to *all* residents within the first 5 days.

63. The harm caused to migrants by lack of access to healthcare during the pandemic cannot now be undone. However, an acknowledgement from the Government, in particular the DHSC and the Home Office, of that harm caused would be a step in the right direction to rebuilding trust.

64. Finally, in the spirit of *radical reform,* MPCAG invite the Chair to the Inquiry to make an overarching recommendation that governmental action is taken to ensure that the recommendations from this Covid-19 Inquiry, and any future inquiry, are binding. This approach would be wholly consistent with the recent report of the House of Lords' Statutory Inquiries Committee "*Public inquiries: Enhancing public trust" (September 2024)* that expressed the following concern: ***".. too often, inquiries are failing to meet their aims because inquiry recommendations are not subsequently implemented, despite being accepted by the Government. This is inexcusable, as it risks the recurrence of a disaster and undermines the whole purpose of holding an inquiry in the first place."***[18]

65. Making an overarching recommendation as to the binding nature of the Inquiry's work would ensure not only better value for public expenditure in the extant Inquiry but would compel an expectation of reform to guarantee that the UK is better prepared *when* the next pandemic arrives. It would also be a meaningful step towards Government accountability for institutional wrongs committed in relation to access to primary healthcare during the pandemic.

66. If the UK Government is to respond effectively to future public health crises, it must develop an inclusive framework that recognises and addresses the vulnerabilities of all population groups, particularly migrants. This includes dismantling exclusionary immigration policies, fostering trust between migrants and healthcare systems, and ensuring that public health strategies are genuinely equitable.

67. By adopting MPCAG's recommendations, the Chair will send a clear and committed message that truly '***every*** *story matters'* by offering everyone—regardless of immigration status—access to the healthcare they need.

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[18] House of Lords' Statutory Inquiries Committee "*Public inquiries: Enhancing public trust"* (Sept 2024), p. 3