Witness Name: MPCAG

Statement No: 1
Exhibits: 2
Dated: 04/10/2024

UK COVID-19 INQUIRY
MODULE 4

WITNESS STATEMENT OF THE
MIGRANT PRIMARY CARE ACCESS GROUP

The Migrant Primary Care Action Group ('MPCAG') says as follows:

1. For the purpose of our participation in Module 4 of the Covid-19 Public Inquiry, we have formed a collective of four organisations known as the Migrant Primary Care Access Group ('MPCAG') comprising: Doctors of the World ('DOTWUK') [MPCAG/1 - INQ000401089], The Joint Council for the Welfare of Immigrants ('JCWI') [MPCAG/2 - INQ000401109], Kanlungan [MPCAG/3 - INQ000401120] and Medact [MPCAG/4 - INQ000401131]. This statement is prepared jointly by senior employees of those organisations: Ms. Anna Miller (DOTWUK – Head of Policy and Advocacy), Ms. Mary Atkinson (JCWI – Campaigns and Networks Manager), Ms. Lorie Halliday (Kanlungan – Director) and Mr. James Skinner (Medact – Campaign and Programme Lead: Health and Human Rights). All are willing to give oral evidence at the hearing and can speak knowledgably about matters contained within this joint statement.

2. This composite statement on behalf of all MPCAG organisations is prepared in response to the Chair's Request for Evidence pursuant to Rule 9 of the Inquiry Rules 2006.

3. In accordance with the Module 4 Provisional Outline of Scope, this statement identifies the barriers and inequalities that prevented access to the Covid-19 vaccine and therapeutics for a significant proportion of the migrant community. It will address the impact over the "relevant period" as set by the Inquiry, i.e. 30 January 2020 – 28 June 2022. On occasion it has been necessary to refer to dates outside of that period to contextualise the origin and implementation of certain barriers.

4. Accounts provided by individuals as case studies have been anonymised for reasons of confidentiality.

5. This statement is structured as follows:

A: Executive Summary of the Government's failings, lessons learned and recommendations [at § 7 to 18]

B: Introduction of the MPCAG organisations, their specialist expertise and the community they serve [at § 19 to 37]

C: Identification of the wider migrant community and vaccine statistics [at § 38 to 66]

D: Barriers and inequalities experienced by the migrant community in accessing vaccines and therapeutic treatment [at § 67 to 226]

E: Impact of the identified barriers [at § 227 to 232]

F: Action taken by MPCAG to shoulder state responsibility to counteract the identified barriers [at § 233 to 267]

G: MPCAG's engagement with the Government and health services during the Covid-19 pandemic [at § 268 to 294]

H: Recommendations to remove barriers [at § 295 to 305]

Identified themes:

6. Several intersectional themes arise from MPCAG's evidence and illuminate this statement:

- Inequality and discrimination;
- Structural and institutional racism;
- Violations of privacy and confidentiality;
- Denial of agency, dignity and information; and
- Impact of social isolation and impoverishment on healthcare inequality.

A: EXECUTIVE SUMMARY OF GOVERNMENT FAILINGS AND RECOMMENDATIONS

7. Migrants *as a class* feature a disproportionate number of individuals who faced both *increased exposure* to contracting Covid-19 and an *increased risk* of experiencing severe symptoms and fatalities caused by Covid-19. As such, they were deserving of particular care and consideration in Government planning to facilitate fair, reasonable, and equitable access to the Covid-19 vaccine and therapeutics to prevent individual harm to health and in the interests of wider public health and consider whether, and if so, what positive action might have been required to promote and ensure such access and avoid practices which had discriminatory outcomes and impacts on migrants as a group or some part of that group.

8. Instead, they faced significant and interwoven barriers embedded by decades of authoritarian and harsh immigration policies (known as Hostile Environment policies), structural racism, and socio-economic inequalities that all contributed to their deep-rooted mistrust of authorities, and an inability and/or reluctance to access healthcare during the pandemic.

9. The most pernicious barriers to vaccines and healthcare for migrants during the pandemic were government-created and designed to enmesh access to healthcare with immigration control. These barriers were both well-known and well-documented prior to the pandemic. For years experts in the field called on the Government to remove such migrant healthcare barriers to protect wider public health. These warnings went unheeded.

10. Although the Government did take some reactive or short-term action relevant to the migrant community during the Covid-19 pandemic, for example, by adding Covid-19 to the schedule of exemptions from NHS charging (which is standard practice for all communicable diseases), or by belatedly confirming that vaccines could be accessed without ID or an NHS number and declaring an amnesty for undocumented migrants to access the vaccine, the evidence is unequivocal: these measures were ineffective and failed for being too little and too late.

11. The risk of, or actual exclusion from healthcare for migrants by the structure created and embedded over previous decades could not be easily or effectively dismantled by such belated and short-term actions.

12. The deep-rooted fear and mistrust of the state or statutory bodies and organisations felt by migrants, caused by Hostile Environment policies, cannot be switched on and off in times of national emergency.

13. The only tenable, evidence-based, and credible recommendation to ensure effective and meaningful removal of barriers to healthcare for migrants, in the interests of wider public health both now and in future pandemics, is for these Hostile Environment policies (NHS charging, data sharing and No Recourse to Public Funds) to be permanently repealed. Anything less than this would be ineffective.

14. Migrant access to treatment for Tuberculosis ('TB') and HIV reinforces this point. Despite treatment for TB and HIV being exempt from NHS charging, exemption alone is insufficient.

Research corroborates that the existence of the wider NHS Charging regime significantly deters access to treatment for migrants, even if treatment is formally exempt from charges.

15. The following provides a headline summary of the Government's failings, which should inform the Inquiry's findings on lessons learned and makes recommendations for change that must necessarily be implemented now to ensure effectiveness in any future pandemics. To delay and/or refuse to implement these changes unless or until we are in the midst of a future healthcare emergency will be too late and will cost lives - migrant lives.

(1) **<u>Failure to prioritise public health over immigration policy:</u>** During the pandemic, the Government demonstrated that it was willing to sacrifice public health policy and objectives in the interest of maintaining its long-term 'hard-line' approach to immigration. Short-term actions or exemptions of policies that excluded migrants from healthcare were ineffective in addressing public health concerns and risks. The barriers identified below could and should have been permanently removed or repealed in the interests of wider public health. Importantly, it is not only NGOs operating in this field that were and are calling for the repeal of Hostile Environment policies in the interests of public health. Throughout the pandemic NHS staff and scores of Royal Medical Colleges formed a unified voice in calling for this action.

<u>Recommendation:</u> Public health must be prioritised over immigration considerations. To that end the NHS charging regime, the No Recourse to Public Funds condition and data-sharing practices between the NHS, Department of Health and Social Care, and the Home Office must be repealed.

(2) **<u>Ineffective communication of Covid-19 being exempt from NHS charging</u>:** From 29 January 2020 the Government included Covid-19 as an exemption from the NHS charging regime applicable to certain migrants, however, to date *charges continue to apply* to treatment for long Covid or other health complications caused by Covid [MPCAG/30 - INQ000401121].[1] The NHS charging regulations require charges to be levied for most secondary and tertiary healthcare provided to migrants, unless an exemption applies. The framework is extraordinarily complex and frequently misunderstood by NHS Trusts, with treatment being incorrectly refused or charges being erroneously applied and pursued. The NHS is *required* to share information with the Home Office on patients' immigration status and unpaid debt, which can be used as a basis to refuse future immigration applications or to pursue immigration enforcement action. This has caused many migrants

[1] 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. This was later amended to refer to *"Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2)"* by Regulation 2(4) of the National Health Service (Charges to Overseas Visitors) (Amendment) Regulations 2022/19.
Pursuant to an amendment made on 10 February 2020 to DHSC's guidance "NHS cost recovery - overseas visitors" the then-called "novel coronavirus (2019-nCoV)" was added to the list of exempt services.

to view the NHS with suspicion, fear, and profound mistrust. The Government failed to properly communicate the charging exemption to migrant communities in a clear and accessible manner to reassure and facilitate access to Covid -19 treatment and vaccinations.

Recommendation: Current Covid-19 exemptions from the charging regime must extend to *all* health consequences of the virus and this must be supported by targeted, clear and accessible Government messaging to rebuild trust and facilitate access to such healthcare for all migrants. The longer-term and more crucial recommendation is for all NHS charging to be repealed.

(3) **Data sharing between NHS and Home Office:** Data sharing between the NHS, the Department of Health and Social Care, and Home Office deters migrants, particularly undocumented migrants or those with precarious immigration status or who perceive their status to be precarious, from sharing their personal information with healthcare workers for fear of immigration enforcement action including detention and removal. This fear and mistrust intensified during the pandemic causing many such persons to avoid accessing the vaccine or therapeutics for fear of the perceived or actual immigration consequences.

Recommendation: Data sharing between the NHS, the Department of Health and Social Care and the Home Office must cease. NHS England and the Department of Health and Social Care must implement a permanent firewall to ensure that confidential patient data will never be shared with the Home Office or other bodies for the purposes of immigration enforcement.

(4) **Failure to suspend the No Recourse to Public Funds ('NRPF') condition**: The NRPF condition applies to roughly 2.58 million migrants in the United Kingdom (UK) [MPCAG/110a - INQ000508361]. It places a significant proportion of these individuals in a financially precarious situation by barring access to any social welfare benefits as a financial safety net if they face destitution whilst in the UK. Whilst the Government enacted expansive regulations and policies providing a financial safety net to the wider public facing unemployment and loss of income during the pandemic, the NRPF remained in place throughout. An absence of an equivalent financial safety net for migrants who risked loss of income or employment directly undermined the public health guidance compelling individuals to self-isolate if symptomatic. Primary healthcare, including the Covid-19 vaccine and treatment, are often conflated by some migrants as being a public fund from which those subject to the NRPF condition are excluded. Together with the fear and confusion of the NHS charging regulations, and the risk of facing an unpayable debt to the NHS triggering information being reported to the Home Office, the imposition of the NRPF condition operated to deter migrants from accessing the vaccine and therapeutics.

Recommendation: **The NRPF condition must be revoked, and this change properly and clearly communicated to all migrant communities. In any event during any future pandemic the condition must be immediately suspended as a prioritity and effectively communicated to those affected.**

(5) **Vaccine access based on a model that had a direct impact of excluding migrants**: The issue of GP practices routinely refusing to register migrants was widely reported and well known to Government prior to the pandemic. The Home Office itself operates a policy that inhibits the destitute asylum seekers it accommodates from accessing GP registration. Further, digital exclusion, fear of NHS and Home Office data sharing, and confusion regarding NHS charging deters migrants from registering with a GP. Registration with a GP is the main gateway for migrants to obtain an NHS number. Yet, despite being aware of this, the Government implemented a mechanism for vaccine booking and for identification of priority vaccine cohorts linked to clinical vulnerability based on a model that knowingly and directly inhibited access for many migrants who are not registered with a GP and do not have an NHS number. An NHS number was required to book a vaccine and identification for early vaccine priority was based on medical records. This created a substantial barrier for many migrants. Belated Government efforts to communicate that vaccines could be administered without an NHS number were inadequate to reassure or reach migrant communities effectively with no or inadequate monitoring of such access or uptake.

Recommendation: Decisive action must be taken to ensure comprehensive GP registration and access to primary health care for all migrants. Until this is achieved, vaccine and therapeutic access must not be made contingent on an NHS number. Self-identification of clinical vulnerabilities must be facilitated. The availability of both mechanisms must be properly communicated to migrant communities and monitored to assess efficacy.

(6) **Failure to identify or prioritise migrants in high-risk settings:** Despite public messaging urging social distancing and isolation for the benefit of wider public health, during the pandemic the Government procured several former-military barracks to use as large-scale asylum accommodation where overcrowding and shared facilities significantly increased the exposure to Covid-19 for those placed there by the Home Office. Notwithstanding the health dangers associated with procuring this accommodation contrary to the Government's own advice [MPCAG/5 - INQ000401142] at no stage did the Government identify or prioritise these sites, or other overcrowded asylum accommodation sites, as being high risk and eligible for vaccine priority.

Recommendation: In future pandemics, the Government must comply with its own guidance for those in asylum accommodation ensuring single rooms with ensuite facilities to reduce transmission and reduce health risk. In any event high-risk and large-scale sites accommodating high numbers of individuals must be prioritised for early vaccines access.

(7) **Failure to enable migrants to extend their visas to avoid becoming 'undocumented':** For migrants on fixed-term visas that expired during the pandemic, their inability to travel or leave the UK during lockdowns rendered them in breach of the immigration rules and deemed to be 'undocumented' / an 'overstayer'. While the Home Office's 'Exceptional Assurance' scheme assured some migrants that overstaying a visa for this reason would not lead to adverse immigration consequences, it did not provide a mechanism by which those migrants affected were able to secure or extend their leave. This left those affected in the UK without any formal status or enforceable rights, reliant on a discretionary scheme that lacked detail and precision as to its operation and enforceability. It was also unclear whether the Immigration Health Surchare (paid at the time of the initial application) was also extended under the exceptional assurance scheme to allow on-going access to healthcare without charge. This, combined with fear of the Hostile Environment policies applicable to undocumented migrants, inhibited their ability to access the vaccine and therapeutics and left them more vulnerable as a consequence.

Recommendation: Effective mechanisms must be implemented and communicated to enable immediate and affordable visa extension applications to be made, the fee for which should be no higher than processing costs (i.e non-profit making). The mechanism should ensure automatic extension of statutory leave and allow for immediate digital and paper communication of that status both whilst being processed and when granted meaning that such statutory and enforceable rights are accessible.

(8) **Failure to consult and collaborate with the relevant NGO sector to reach migrants:** The Government did not consult with frontline migrant organisations at the early stages of the pandemic in a way that would have enabled an effective strategy to be identified and implemented to facilitate access to the vaccine and therapeutics for migrants. Even when barriers were repeatedly raised (in particular by MPCAG), the Government refused to take the full and immediate action that evidence showed was necessary i.e., by ending or suspending NHS charging, data sharing and the NRPF condition. The Government failed take any or any adequate steps to mitigate the widespread distrust of the Home Office and NHS amongst many migrants, which meant that any Government guidance or information, for instance about exemptions to NHS charging or the amnesty for undocumented migrants, did not reach, or was not believed by migrants. Without the additional efforts of NGOs during the pandemic to counter Government-imposed barriers to healthcare and mistrust (efforts that were not supported by provision or funding by the Government) the irremediable harm to the migrant community would have been far wider and greater.

Recommendation: Early and effective identification of and consultation with specialist migrant NGOs must be prioritised and frontline outreach efforts must be properly funded and resourced in collaboration with relevant organisations.

(9) **Inadequate communication:** The Government's poor and inadequate communication strategy failed to reach many 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 information. Although provision was made for British Sign Language, no other languages were made available either in real time or by way of translated recording. Time-critical public health information was not translated with sufficient speed, nor disseminated in accessible formats (including non-digital means) to access this cohort. This, combined with existing distrust of Government messaging on healthcare for migrants, contributed to the significant spread of misinformation amongst many migrant communities, further fuelling hesitancy in accessing the vaccine or health services.

Recommendation: Clear and targeted communication of public health information must cater to the particular language needs of migrant communities.

16. These recommendations are critical and increasingly urgent. Since the pandemic, the Government has introduced ever more draconian and punitive immigration legislation that will endanger public health, undermine public health efforts, and further exclude migrants from healthcare services in future pandemics.

17. The Covid-19 Inquiry has recognised the importance of examining barriers to healthcare for migrants, which will necessarily involve an independent analysis of how the Hostile Environment policies impacted migrants and wider public health during the pandemic.

18. This Inquiry presents a pivotal and critical opportunity to make robust and evidence-based recommendations that re-state the fundamental and inalienable right to equality, dignity, and access to healthcare for all and to remove discriminatory barriers to such access and identify positive actions that will facilitate and enable such access.

B: INTRODUCTION OF THE MPCAG AND THEIR SPECIALIST EXPERTISE

DOTWUK

19. Médecins du Monde is a globally recognised independent humanitarian organisation with a mission to facilitate equitable access to medical services for marginalised and disadvantaged communities. Founded in 1979, Médecins du Monde currently manages or aids more than 350 initiatives in over 80 countries. Its primary focus is delivering essential healthcare to those excluded from mainstream healthcare systems.

20. Doctors of the World UK ('DOTWUK') is the England and Wales branch of Médecins du Monde, founded in 1998. Its core purpose is to enhance healthcare accessibility for marginalised and excluded communities. DOTWUK operates volunteer-led medical clinics in England and an

advice line available across England, Scotland and Wales staffed by general practitioners, nurses, midwives, and caseworkers.

21. DOTWUK is a globally recognised independent humanitarian organisation with a mission to facilitate equitable access to medical services for marginalised and disadvantaged communities. Founded in 1979, DOTWUK currently manages or aids more than 350 initiatives in over 80 countries. Its primary focus is delivering essential healthcare to those excluded from mainstream healthcare systems.

22. The branch of DOTWUK in England and Wales was founded in 1998. Its core purpose is to enhance healthcare accessibility for marginalised and excluded communities. DOTWUK operates volunteer-led medical clinics in England and an advice line available across England, Scotland and Wales staffed by general practitioners, nurses, midwives, and caseworkers.

23. Leveraging grassroots efforts and extensive expertise, DOTWUK engages in qualitative and quantitative research, and collaborates with academic institutions. It has had a substantial impact on shaping public health discussions concerning vulnerable refugees, migrants, and undocumented people in the UK.

24. Most patients aided by DOTWUK lack formal immigration status but have resided in the UK for a significant period. These individuals often endure dire poverty and profound social isolation.

25. For the years 2020-22 inclusive, DOTWUK supported 2,152 people to access NHS services. Of those, 57% had no formal immigration status (this includes people whose asylum claims were refused), 29% were asylum seekers, 7% had a valid visa, 2% were EU citizens with a right to reside in the UK, 1% were refugees and 1% were British citizens.

JCWI

26. JCWI is a renowned charitable organisation founded in 1967, dedicated to advancing justice, fairness, and equality within the realm of British immigration and asylum law. This includes conducting in-depth policy research, parliamentary advocacy, campaigns and strategic communications, community organising and capacity building, and providing legal assistance and strategic litigation services to protect migrants' rights. With over 50 years of experience, JCWI is a leading advocate for migrant justice within both the migrant sector and the broader public.

27. JCWI leverages its frontline legal work to inform its advocacy efforts. It produces well-researched policy reports and briefings that provide evidence of the impact of the UK's immigration system. Through these reports, it makes recommendations for policy reforms, while also engaging in campaigns and fostering alliances focused on migrant justice at both national and local levels. JCWI's legal team provide immigration advice and representation to people in all areas of the immigration and asylum system including but not limited to: asylum seekers, refugees, refused asylum seekers, refugee family members, people in detention,

undocumented migrants, people on the 10-year route to settlement, survivors of trafficking / modern slavery and migrant workers.

28. JCWI is a membership-based organisation. Its members are a mix of organisations and individuals who come from all walks of life – many have lived experience of migration, many are simply people concerned about rising intolerance and hostility aimed at migrants.

29. JCWI supports around 200 clients, providing legal representation and holistic support. It also runs two free legal advice helplines; one for UNISON members and one for undocumented people - and every 6-weeks a clinic at Yarl's Wood Immigration Detention Centre. At least 80% of JCWI's clients are undocumented, roughly 65% are supported to make asylum claims, while close to 100% make human rights claims. A significant minority are victims of trafficking and at any one time JCWI represent several people who are in immigration detention.

Kanlungan

30. Kanlungan is a registered charitable incorporated organisation consisting of several Filipino and Southeast and East Asian grassroots community organisations. Kanlungan works for the welfare and interests of migrants, refugees, and diaspora communities from the Philippines and East and Southeast Asia living in the UK.

31. Kanlungan works across the UK providing immigration, welfare, and employment advice. It organises cultural and spiritual activities, assists its members with access to mental health and wellbeing support, and campaigns for the rights of its members through lobbying local and national government.

32. Between 2021 and 2022 Kanlungan supported approximately 2,081 individuals. The majority of their services users are in the UK on visas that are attached either to their work (such as domestic workers and health and social care workers) or attached to their spouse/partner. In most instances, those who become undocumented previously held valid work visas.

33. Due to the informal nature of employment and the undocumented status of many, it is not possible to identify with accuracy the number of Filipinos working in the healthcare, domestic work or social care sector. However, based on a rough estimate, there are 200,000 Filipinos in the UK of which 40-50% are employed in these sectors.

MEDACT

34. Medact, established in 1992, is a collective of dedicated healthcare professionals who strive for a world that is safer, fairer, and healthier. This membership organisation focuses on investigating and analysing evidence pertaining to the social and environmental factors that have a detrimental impact on health.

35. Comprising just over 1000 member including doctors, nurses, public health professionals, academics and students, Medact provides crucial support to healthcare workers in identifying

and addressing issues that contribute to health disparities. Medact has a further network of 5000 non-members who engage with its work. In addition, there are 300 active volunteers who are heavily involved in Medact's campaigning and advocacy work.

36. By fostering collaboration between frontline workers directly affected by policies and experts in academia and public health to produce research and evidence-based advocacy, Medact brings a unique perspective and specialised knowledge to the ongoing policy discussions surrounding health inequality. It seeks to address the social, political, and economic factors that undermine refugee and migrant health, which then widens health disparities.

37. Together with Migrants Organise, Medact is part of the Patients Not Passports Network that works with hundreds of health workers, migrant and community organisers, and NHS campaigners. Support is provided to local groups advocating for improved access to healthcare for migrants in Brighton, London, Oxford, Bristol, Birmingham, Sheffield, Liverpool and Manchester. Through these networks Medact offers ad hoc support to migrants, who are often undocumented, facing NHS charges but does not undertake individual casework.

C: IDENTIFICATION OF THE MIGRANT COMMUNITY AND VACCINE STATISTICS

Identification of MPCAG cohort and the wider migrant community

38. As a Core Participant, MPCAG's evidence is giving a voice to one of, if not the largest, cohort of individuals in Module 4.

39. As of June 2021, the UK's population was made up of an estimated 9.6 million foreign-born people (i.e., migrants), the equivalent of **14.5% of the population** [MPCAG/6 - INQ000401153].

40. For ease and in the interests of succinctness, the terms "migrant" or "migrant community" are used within this statement, but it is important to highlight at the outset that the individuals represented by MPCAG are extremely diverse depending on their immigration status and individual circumstances. Equally important to note is that categorisation of migrants based on their immigration status is not a static exercise. An individual's immigration status may have changed during the course of the Covid-19 pandemic, and therefore is transient in nature.

41. The following is a non-exhaustive list of the different sub-groups to which MPCAG seek to give a voice in their evidence to the Inquiry:

    - Asylum seekers whose applications remains outstanding.
    - Failed asylum seekers who are appealing a negative decision, appeal rights exhausted and/or are seeking to submit a fresh claim.

- Failed asylum seekers facing removal (but who could not be removed during the pandemic).
- Destitute asylum seekers and failed asylum seekers reliant on Home Office accommodation.
- Asylum seekers who have been granted refugee status or humanitarian protection.
- Migrants with long-term leave to remain.
- Migrants with fixed term leave to remain.
- Migrants on a dependency visa or subject to on-going eligibility conditions.
- Migrants subject to a 'No Recourse to Public Funds' (NRPF) condition.
- Unaccompanied or separated migrant or asylum-seeking children.
- Migrants detained in immigration detention.
- Migrants incarcerated in prison (on remand, serving a sentence or detained under immigration powers).
- Migrant victims of human trafficking or modern slavery.
- Undocumented migrants with no lawful immigration status (who either entered the UK without permission, entered lawfully but overstayed their visa, or did not leave the UK after their claim for asylum was refused).

Characteristics specific to the migrant community

42. Within the migrant community there are certain prevalent and well-documented characteristics that render this group exceptionally vulnerable such as high levels of destitution, chronic mental health conditions and social isolation. Some of these characteristics such as ethnicity and disabilities, protected under the Equality Act 2020, placed certain migrants at heightened health risk from Covid-19.

43. The available research and statistics also demonstrate that employed or working migrants primarily performed (and continue to do so) front-line roles, particularly within the health and care sector. For these individuals, it was not possible to work remotely or from home during the pandemic and as such they were at increased risk of exposure to Covid-19.

Mental health disability

44. Many individuals within the asylum-seeking and refugee community have experienced significantly high levels of trauma arising from sexual, physical, and psychological violence, torture, trafficking, exploitation and/or loss in violent and distressing circumstances. This makes them more susceptible to mental health conditions and other disabilities, including post-traumatic stress disorder (PTSD), major depression, and anxiety [MPCAG/7 - INQ000401163].

45. According to research, asylum seekers are five times more likely to have mental health needs than the general population. More than 61% experience severe mental distress [MPCAG/8 - INQ000401174].

46. Although statistics in some reviews do vary, the most recent studies of asylum seekers (conducted in 2015) reported an average of 43% of adults suffering from depression and 25% suffering from PTSD [MPCAG/7 - INQ000401163]. Amongst refugee children and adolescents, 36% are reported to suffer from PTSD and 18% from depression [MPCAG/9 - INQ000401185].

Destitution and household overcrowding

47. More than a quarter of destitute households in the UK in 2022 were headed by foreign-born individuals. The risk of destitution for migrants is 35% higher than the average rate [MPCAG/10 - INQ000401090].

48. As a result of poverty, migrant households face increased overcrowding and poor housing conditions, both of which increased the risk of exposure and harm from Covid-19. Put in statistical terms, in the UK migrants had 22% higher odds of infection during the second wave of the pandemic compared to the UK-born population, and household overcrowding accounted for 32% of these increased odds [MPCAG/11 - INQ000401100].

49. In addition, poverty was a driver that forced people to continue to undertake front-line work, at increased exposure risk, to avoid further financial hardship. Linked to this was the increased exposure to Covid-19 infection through being reliant on public transport. It is reported that between December 2020 and February 2021, those in the most deprived 40% of the population were 3 to 5 times more likely to use public transport and up to 8 times more likely to use taxis compared to those in the top 20% [MPCAG/12 - INQ000273843].

Digital exclusion linked to destitution

50. According to a 2023 Ofcom Report, socio-economic status is a significant factor in digital exclusion.[2] Ofcom estimates that in October 2023 about 2.4 million (+/- 500,000) UK households with fixed broadband found it difficult to afford their fixed broadband service and 2.4 million (+/- 500,000) UK households with a mobile phone had difficulty affording their mobile phone service.

[2] Ofcom *Online Nation* 28 November 2023 p15 **[MPCAG/12a - INQ000474436]**

51. Among the lowest socio-economic households *(which we know from the preceding section relating to destitution includes a significant portion of migrants)*, around 2.4 million (21%) do not use the internet at home, and 3.6 million users (38%) are classified as 'narrow' users.

52. During and after the pandemic there was a move to digitalisation of primary care with virtual appointments replacing face-to-face consultations. This has amplified existing inequalities in accessing healthcare for migrants due, *inter alia*, to digital exclusion [MPCAG/15 - INQ000401104].

Black, Asian and Minority ethnicity ('BAME')

53. From 1 September 2020 to 22 May 2021, Asian communities experienced up to double the rate of infection compared to those from White British backgrounds [MPCAG/12 - INQ000273843].

54. Black men were twice as likely to die from Covid-19 compared to White British men during the first wave of the pandemic, and 70% more likely to die during the second wave. The South Asian community comprises 1 in 13 of the population, yet they accounted for 1 out of 10 Covid-19 deaths [MPCAG/12 - INQ000273843].

55. Furthermore, underling health conditions such heart disease, stroke and diabetes that increase the mortality risk from Covid-19 are more common in people from minority ethnic backgrounds [MPCAG/12 - INQ000273843].

56. In so far as the evidence shows that Covid-19 had a disproportionate impact and higher mortality rate on black, Asian and minority ethnicity (BAME) communities than the white British population, it is materially relevant that the Annual Population Survey 2019 showed that 50% of the BAME population in the UK were foreign-born thus falling within the definition of the migrant community for current purposes [MPCAG/16 - INQ000401105].

57. Notably, the Government's SAGE research and recommendation paper expressly identified concerns that, based on previous national vaccination programmes, there was a significant risk that vaccine uptake for Covid-19 would be lower amongst minority ethnic groups. Despite this, the paper failed to identify how this impacted minority ethnic migrants in the UK or how immigration policies create access barriers [MPCAG/17 - INQ000401106].

Frontline workforce

58. In 2020 and 2021 it is estimated that migrants comprised 18% of the employed workforce in the UK [MPCAG/18 - INQ000401107] Migrants were particularly over-represented in the hospitality sector (28% of workers), transport and storage (26% of workers), information and communications (25% of workers), or health and social work (21% of workers) [MPCAG/18 - INQ000401107] At the same time, other barriers prevented or deterred access to the Covid-19 vaccine.

59. East and Southeast Asian migrants accounted for 23% of the health and social workforce in 2020, only exceeded by Sub-Saharan Africa migrants, who made up 27% of health and social

workers. Occupations such as health professionals, food preparation and other skilled trades, and drivers and machine operators accounted for the highest share of non-EU born workers in 2020 (18%, 17%, and 16%, respectively) [MPCAG/18 - INQ000401107].

60. In 2020, around 200,000 Filipinos were living in the UK and made up the third largest nationality working in the NHS after Britons and Indians [MPCAG/19 - INQ000401108] Many migrant workers, including Filipinos, live in overcrowded accommodation with other health and care workers due to low wages and financial pressures, which further increased their exposure risk to Covid-19.

61. Britain has one of the highest levels of foreign-born nurses in the EU, with an estimated 40,000 Filipino staff employed in the NHS in 2020 [MPCAG/20 INQ000401110]. There was a disproportionate number of Covid-19 deaths among Filipino health and care workers in the UK. For example, in May 2020, 22% of Covid-19 deaths amongst NHS nurses were Filipino.[3]

Quantifying the migrant community

62. Although it is not possible to quantify with precision the number of asylum seekers, migrants, and undocumented migrants that were in the UK during the Covid-19 pandemic, Home Office statistics establish that it amounted to millions of individuals. A substantial proportion of these would have been impacted by the identified inequalities and barriers to accessing vaccines and therapeutics that the Government either maintained or failed to remove and/or counteract [MPCAG/21 - INQ000401111, MPCAG/22 - INQ000401112, MPCAG/23 - INQ000401113]:

    i. Outstanding asylum applications. At the end of 2020 there were 51,321 asylum applications awaiting an initial decision. This rose to 81,978 by the end of 2021 and to 131,182 by the end of 2022.

    ii. Asylum accommodation. At the end of 2020 there were 59,717 destitute individuals reliant on asylum accommodation. By the end of 2021 this totalled 79,737 and by the end of 2022 this totalled 105,522 individuals.

    iii. Immigration detention. 14,773 individuals entered immigration detention in 2020, 24,497 entered detention in 2021 and 20,446 entered detention in 2022.

    iv. Enforced returns. In the year ending September 2020 there were 4,353 enforced returns. This totalled 2,830 for the 2021 period and 3,531 for the 2022 period.

    v. Work-related visas. 125,176 visas were granted in 2020, 239,987 in 2021 and 267,670 in 2022.

    vi. Family-related visas. 154,658 were granted in 2020 and 280,776 were granted in 2021, and 48,107 were granted in 2022.

[3] Huffpost *Why So Many Filipino Health Workers Are Dying Of Covid-19* 12 April 2021, HSJ *At least 23 nationalities among NHS staff killed by covid* 19 May 2020 **[MPCAG/20a - INQ000474437] and [MPCAG/20b - INQ000474440]**

vii. Undocumented migrants: At the end of 2017 there were estimated to be between 800,000 and 1.2 million people living in the UK without a valid residence permit, equating to between 1.2 and 1.8% of the UK's population of 65 million [MPCAG/24 - INQ000401114]. This figure represented one of the highest undocumented migrant populations in Europe [MPCAG/24 - INQ000401114]. According to JCWI, the majority of the undocumented cohort comprises those who had lawful status when they arrived in the UK but subsequently lost their status often through no fault of their own [MPCAG/25 - INQ000401115].

Vaccine statistics for migrants

63. According to ONS data, as of July 2022, almost 2 in 5 (40%) Black Caribbean and 1 in 4 (25%) of Black African and White Other adults remain unvaccinated, compared to less than 1 in 10 (8.6%) of White British and Indian (9%) adults [MPCAG/26 - INQ000401116].

64. The proportion of unvaccinated adults was higher for those who are: living in deprived areas, migrants who do not have English as a main language, or who are unemployed, disabled, Muslim and male [MPCAG/26 - INQ000401116].

65. When looking at the timescales for vaccine coverage rates, it is apparent that certain minority ethnic groups lag significantly behind. Indian, White British and Chinese ethnic groups had all reached 75% coverage by July 2021. There was a two-month delay, until September 2021, for "Any Other" ethnic group to reach this level of coverage and an additional four months, until November 2021, for Pakistani and mixed ethnic groups to reach this level. As of January 2023, Black Caribbean, Black African and White Other ethnic groups had yet to reach the 75% threshold [MPCAG/12 - INQ000273843].

66. According to Virus Watch, older migrants (aged 65+) were almost 4 times less likely to have received their second or third Covid-19 vaccine compared to the same aged English cohort [MPCAG/27 - INQ000401117].

D: BARRIERS AND INEQUALITIES EXPERIENCED BY THE MIGRANT COMMUNITY IN ACCESSING VACCINES AND THERAPEUTIC TREATMENT

67. Migrant vaccine uptake and access to therapeutics were inhibited by:

(i) **systemic inequalities and pre-existing healthcare barriers,** and

(ii) **inadequate government efforts** to remove or counteract those barriers and inequalities in the special context of the pandemic.

68. This section summarises the structural inequalities and healthcare barriers that prevented migrants from accessing vaccines and healthcare during the pandemic. It contextualises the underlying distrust and fear created by the Home Office through decades of anti-migrant rhetoric, successive laws and policies restricting access to healthcare services and structural racism and discrimination.

69. The Home Office and wider Government departments failed and/or chose not to properly address or effectively dismantle these barriers that converged and intensified during the pandemic with fatal consequences for the wider migrant community.

70. The main barriers can be summarised as follows:

    i. Hostile Environment laws and policies designed to deter and prevent migrant access to healthcare, including the NHS charging regime, NHS-Home Office data-sharing, and the NRPF condition.

    ii. Chronically low levels of GP registration: systemic refusals by GP practices to register migrants and refugees as patients, particularly those without leave to remain, those living in Home Office accommodation, or experiencing homelessness. This prevented substantial numbers of migrants from accessing an NHS number required for vaccine registration and prevented identification of clinically vulnerable migrants eligible for early vaccination.

    iii. Structural and institutional racism and discrimination experienced by migrants when accessing healthcare and Covid vaccinations, exacerbated by the Hostile Environment policies designed to stoke racial division and racial inequality.

    iv. Socioeconomic barriers such as poverty and destitution, lack of transportation and language barriers, and digital exclusion particularly amongst undocumented migrants.

    v. Restrictions on access to vaccines for those in asylum accommodation or detention including a lack of early vaccine prioritisation for high-risk settings and failure to remove barriers to GP registration and obtaining an NHS number for this isolated cohort.

71. Individually, these barriers were considerable in preventing migrant access to vaccines, but the intersection of the barriers and their overlap exponentially increased their impact in blocking access for certain groups.

72. Many migrants faced a multitude of these interrelated and compounding barriers that were exacerbated by inadequate Government planning and responsiveness prior to and during the pandemic, most notably in the form of:

i. Failure to consider and/or refusal to take direct action to address the impact of or effectively remove barriers to vaccines and therapeutics for migrants requiring suspension of the Hostile Environment policies accompanied by an information campaign to inform healthcare staff and migrant communities of these changes. Government action that was taken failed because it did not go far enough in dismantling the root causes of the most pernicious barriers.

ii. Inadequate Government identification of and responsiveness to vulnerable migrants, including their public health and support requirements during the pandemic, particularly for those in Home Office accommodation.

iii. Poor communication strategies to ensure public health information was shared in a time-sensitive manner relevant to risk within migrant community spaces, in an accessible format and in diverse languages.

iv. Hostile and poor decision-making regarding the nature of asylum accommodation and failure to remove barriers or promote or prioritise access for those living in remote, isolated and overcrowded asylum accommodation that compounded mistrust and vulnerability.

Systemic and structural inequalities and healthcare barriers

The 'Hostile Environment'[4]

73. The Hostile Environment laws and policies created direct barriers preventing access for certain migrants to primary health care services, as well as preventing them from accessing a raft of other services and basic amenities that indirectly reinforced the healthcare barriers and wider inequalities.

74. The implementation of the Hostile Environment enmeshed immigration enforcement and access to healthcare and resulted in deep-rooted and widespread fear and mistrust of the UK's healthcare system amongst migrant communities.

75. These measures were introduced and entrenched before the Covid-19 pandemic struck and continue, unaltered, after the pandemic despite there being unequivocal evidence of the detrimental impact of these measures to wider public health.

[4] The so-called "Hostile Environment" was established under Theresa May as Home Secretary, later re-named as the "Compliant Environment" from 2018 under the then-Home Secretary Sajid Javid. The change of nomenclature does not reflect any change of policy substance or intent.

76. To summarise briefly, from 2012 the UK government introduced far-reaching legislation to deter unlawful or irregular migration by creating a "*really hostile environment*" [MPCAG/28 - INQ000401118] This Hostile Environment comprises a raft of policies intended to make the lives of irregular migrants exceptionally difficult by creating hostility, vilification and treating them as being less deserving of dignity and humanity than British citizens [MPCAG/25 - INQ000401115]

77. Crucially, the Hostile Environment policies apply not only to undocumented migrants. They apply to migrants living in the UK with a lawful visa such as those with limited leave to enter and remain and to those seeking extensions of their leave whilst awaiting decisions.

78. In practical terms, the Hostile Environment measures require members of the wider British public to adopt the role of immigration enforcement officers in policing undocumented migrants' access to private rented accommodation, bank accounts, driving licences, social welfare benefits and, importantly for the Inquiry's purpose, healthcare services.

79. Relevant to barriers preventing migrants from accessing healthcare services, and in particular the Covid-19 vaccine and therapeutics, the primary policies relate to NHS charging, NHS and Home Office data sharing and NRPF.

80. The Government's justification for introducing these measures is to encourage undocumented migrants to leave the UK and to deter other migrants from arriving.

81. There is no evidence that the Hostile Environment policies have achieved either of these two objectives. Yet these policies persist.

NHS charging [MPCAG/29 - INQ000401119] [5]

82. Pursuant to Charging Regulations introduced in 2015, overseas visitors (i.e., migrants) must pay for "relevant NHS services" at 150% of the cost to the NHS [MPCAG/30 - INQ000401121]

83. The starting point is that individuals who are not 'ordinarily resident' in the UK are liable to be charged to receive most secondary and tertiary NHS services. This excludes primary care and GP services.

84. The term 'ordinarily resident' is not defined in the relevant legislation or regulations. According to government guidance *"anyone who is subject to immigration control (meaning they need permission to enter or remain in the UK, per section 115(9) of the Immigration and Asylum Act 1999), cannot be ordinarily resident in the UK unless they have Indefinite Leave to Remain, or*

[5] NB. Decisions about specific NHS charges are devolved and governed by separate legislation for Wales, Scotland and Northern Ireland. For a full background on the charging regime in England, see Thomas Powell, House of Commons Library Briefing Paper Number CBP03051: *NHS charges for overseas visitors* 4 May 2020

pre-settled or settled status under the EU Settlement Scheme (EUSS)" [MPCAG/31 - INQ000401122]. Therefore 'ordinarily resident' broadly means any person not living in the UK with settled status or citizenship.

85. Migrants who are otherwise living in the UK on a lawful and valid visa, but do not have full settled status or citizenship, are therefore not 'ordinarily resident' and are subject to the NHS Charging Regulations.

86. The Charging Regulations are subject to complex exemptions:

    i. Some services are out of scope of the Charging Regulations, such as primary care.

    ii. There are specified exempted services, such as treatment in A&E or for infectious diseases, that remain free at the point of access for all.

    iii. Certain cohorts are specifically exempted from the charging regime, such as asylum-seekers, some types of detainees and victims of modern slavery. Separate criteria dictate the scope of exemption for services for these exempted individuals.

    iv. If a migrant has paid the Immigration Health Surcharge ('IHS') as part of their visa application to enter or remain in the UK, they will be exempt from additional charges for the duration of their visa. The amount a migrant must pay depends on the immigration route in which they are applying. For most migrants it is currently £1,035[6] and must be paid up front for the full duration of the visa, for example, £3,105 for a 3-year visa. The health surcharge rose by 66% from £624 to £1,035 a year in February 2024.[7]

    v. If an individual is covered by an international healthcare agreement, they cannot be directly charged for most services (with some limitations) and the NHS body may recoup the charges from patient's home country.

87. Establishing whether someone is "ordinarily resident" based on their immigration status, whether someone falls within a specific exemption category based on their immigration status or experiences and, if so, to what extent certain services are exempted and others remain chargeable, and/or are exempted based on payment of the surcharge or subject to an international agreement, is an exceptionally complex task for NHS Trusts who are responsible for enforcement of the Charging Regulations. The complexity of the NHS charging regulations coupled with the transient nature of immigration statuses means that NHS Trusts as a whole are poorly placed to apply the exemptions designed to ensure vulnerable people are not denied care. NGOs (including DOTW and JCWI) and immigration law experts have long raised concerns

[6] It is £776 per year for students, their dependants, those on a Youth Mobility Scheme visa, and those who are under the age of 18 at the time of application.
[7] The Immigration (Health Charge) (Amendment) Order 2024/55.

that the healthcare charging policy places unrealistic expectations on NHS Trusts [MPCAG/32 - INQ000401123, MPCAG/33 - INQ000401124, MPCAG/34 - INQ000401125].

88. The Charging Regulations additionally prescribe that where an individual is not exempt from the charging regime, front-line NHS staff must refuse non-urgent medical care until the relevant charge has been paid upfront. Alternatively, where urgent care is provided, the relevant NHS Trust must pursue payment of the charge from the recipient of treatment. For debts of more than £500 that have been outstanding for more than 2 months, the NHS Trust *must* report this person and pass this information on to the Home Office [MPCAG/31 - INQ000401122].

89. This adds considerable time pressure to front-line medical staff who must quickly ascertain whether an individual is exempt from the charging regime based on complex factors related to their immigration status, in order to determine whether the medical treatment required is sufficiently "urgent" to be provided without prior payment.

90. Evidently, the scope for misapprehension or misapplication of the Charging Regulations is expansive. In October 2020, DOTW published a report examining the impact of the NHS charging regulations [MPCAG/36 - INQ000401127]. The data, which formed the basis of the report's findings, were collected from individuals accessing DOTW's Hospital Access Project ("service users") between 01 July 2018 and 31 July 2020. The criteria to access the service was (i) an individual who had been assessed by an NHS service as not 'ordinarily resident' in the UK and (ii) refused access to an NHS hospital or non-primary care related NHS services in the community; or (iii) asked to pay for an NHS hospital or non-primary care related NHS services in the community before accessing the service. The research found that in 22.2% (6/27) of cases requiring 'urgent' or 'immediately necessary' treatment, the NHS trust did not follow the guidance and apply a charging exemption, and the service user was wrongly charged for their treatment [MPCAG/36 - INQ000401127].

91. There are well evidenced reasons why BAME patients (even those who are British) are less likely to pass the necessary NHS immigration checks. Immigration checks can be a complicated process and requires proof of residency and photographic IDs. Electoral Commission datashows that of the 3.5 million British citizens who do not have any form of photo ID, lack of ID is highest amongst people who are unemployed or renting from a local authority or housing association [MPCAG/37 - INQ000401128]. BAME people are overrepresented in both of these groups. And whilst 26% of adults in England do not have a full driving licence, this rises to 49% for Black people and 39% for people of Asian ethnicity.

92. One of the widest ranging and most devastating impacts of the NHS charging policy is the role it plays in deterring migrants from seeking medical care. The research indicates that fear of accruing large and unpayable debt is preventing and/or delaying migrants seeking care, even in circumstances where there is a clear clinical need, or the healthcare condition is exempt from charge. In some cases, this has led to fatal outcomes.

93. The deterrent effect of the Charging Regulations as a barrier to healthcare is five-fold, even for migrants who are either exempt or who are trying to access a primary care service that ought to be free at the point of access for all regardless of immigration status:

i. The complexity and opaqueness of the charging regime renders it beyond the comprehension of most migrants. A lack of clarity and understanding about eligibility deters migrants from seeking medical care for fear of being charged.

ii. The erroneous charging of migrants, due to the complexity of the regulations, is widely known amongst migrant communities and perpetuates the confusion and fear of the prospect of unaffordable charges and permanent debt owed to the NHS if medical care is sought that ought to be free.

iii. The charging regime requires NHS bodies to record the patient's chargeable status on their NHS record and collect other key data. The requirement on NHS Trusts to then report patients directly to the Home Office for unpaid debts of more than £500 creates profound fear and mistrust. NHS information sharing with and reporting to the Home Office, fear of immigration enforcement as a consequence of seeking medical assistance or unpaid debt, even for medical services that ought to be free such as primary care, is a significant deterrent.

iv. Against this backdrop of uncertainty and confusion amongst both migrants and NHS staff at all levels, the Home Office policy (enshrined in the Immigration Rules) of relying on unpaid NHS debt as a basis for refusing future immigration applications, for which an individual would otherwise be eligible, compounds the deterrent effect [MPCAG/38 - INQ000401129].

v. Those with outstanding asylum applications fear that accessing healthcare services (even if eligible to do so for free) may have an adverse impact on their protection claim.

94. DOTW conducted two studies in 2016 to 2017 at their clinic to assess the effect of charging for NHS hospital services on migrants and on their timely access to necessary healthcare [MPCAG/39 INQ000401130]. One of the key findings of the research was that charging deters and delays vulnerable migrants from seeking the healthcare that they need. Approximately 1 in 5 service users in the DOTW UK clinic were affected by health care charging (21%; 381/1801 and 18.5%; 143/773). Of these, over 1 in 3 were deterred from seeking timely health care because of charging (34.3%; 49/143), including concerns their information would be shared with the Home Office because of the charging process [MPCAG/39 - INQ000401130] The research found this deterrence to be the case even for people with urgent health needs such as heavily pregnant women, people with cancer, people with kidney failure and those suffering from post-stroke complications.

95. A clear example of the powerful deterrent effect created by the NHS charging regime is migrants' access to treatment for Tuberculosis and HIV. TB and HIV fall within the scope of Schedule 1 of the Charging Regulations and are therefore exempt from charge and treatment should be provided free of charge, irrespective of immigration status. This exemption however has little practical effect. The available evidence shows that the deep-rooted fear and mistrust of the wider charging regime prevails and deters migrants from accessing treatment:

i. In England, approximately 75% of TB cases occur in people born abroad. Delays in TB treatment increase risk of morbidity, mortality, and transmission in the community, so early detection is vital. A report by BMC Public Health investigated whether diagnostic delay had increased since the NHS Charging Regime was introduced. The report found that since implementation of the charging regime, there has been a significant delay for TB treatment among non-UK born patients [MPCAG/40 - INQ000137489].

ii. In 2019, 62% (2195/3552) of all new HIV diagnoses in the UK (including people previously diagnosed abroad) were among migrants. A report by the National Aids Trust found that migrants face significant barriers accessing HIV testing, treatment, and care in the UK. It concluded that the impact of the Hostile Environment and in particular the NHS charging deters access to HIV testing and care (despite HIV testing and treatment being free for all). Many participants reported that the Hostile Environment policies deterred them from accessing testing, treatment and care, and that had contributed to their late diagnoses [MPCAG/41 - INQ000235269].

96. In 2013 the Government ran a consultation prior to introducing the current NHS charging regime applicable to migrants. Public Health England's ('PHE') response to the consultation expressly warned that charges presented a public health risk including the risk of easily transmissible respiratory organism such as SARS/influenza epidemic. Specifically, PHE warned (emphasis added):

i. *"Although PHE welcomes that the proposals retain free treatment for infectious diseases and STIs on public health grounds, this alone will not be an effective public health policy for controlling communicable diseases if there are barriers to accessing care, especially primary care, for initial assessment and diagnosis. Cost will be a barrier to some, especially those whose socio-economic circumstances also make them more at risk of acquiring infectious disease."*

ii. *"... Financial and other barriers to accessing primary care (e.g. confusion among health care workers about scope of access entitlements with respect to infectious disease) risk a detrimental effect on screening for infectious disease and hence may facilitate further transmission..."*

iii. *"Restricted and delayed access to health care (especially primary care) can lead to delayed diagnosis and therefore increased risk of further transmission of not only the*

chronic diseases discussed above but also of acute infectious diseases (e.g. respiratory pathogens such as influenza, SARS and MERS-CoV), which can rapidly case serious public health situations and incur significant health service and economic costs."

97. As forewarned and predicted by PHE's evidence to the government in 2013, the deterrent effect created by NHS charging acted as a barrier during the Covid-19 pandemic and undermined public health efforts to control transmission of the virus.

98. Research by Medact demonstrated that 57% of respondents reported that migrants had avoided seeking healthcare because of fears of being charged for NHS care, data sharing and other immigration enforcement concerns. This fear and mistrust was so deeply embedded, that migrants remained deterred from seeking healthcare *even* when trusted case workers advised them that Covid-19 was exempt [MPCAG/42 - INQ000137488].[8] Due to the complex nature of the policies, and the lack of staff and patient knowledge about eligibility, even those entitled to free care under the current policy were deterred from seeking healthcare.

99. This is corroborated by research conducted by JCWI which found that Hostile Environment policies in the NHS hamper public health efforts against Covid-19 by making migrants too afraid to access healthcare even when they are entitled to do so [MPCAG/43 - INQ000401135]. Almost half of all the migrants surveyed (43%) said they would be scared to access healthcare if they got sick during this pandemic. Although JCWI did not ask those surveyed for ethnicity information, 60% of migrants from Africa and the Caribbean report being fearful of seeking healthcare; 56% of Asian respondents said they would be scared.

100. In addition, there is evidence that the charging regime has exacerbated structural racism. As highlighted above, there is considerable ignorance of the operation of the NHS charging regulations within the sector. JCWI's research suggests that as many as 48% of healthcare workers are unaware of how charging regulations operate within their hospitals [MPCAG/43 - INQ000401135]. With such a high proportion of staff unclear on the basis for exemption from charging, there are indications that, with trusts under budgetary pressure, patients are asked to prove their eligibility for free treatment in a discriminatory manner, with those from BAME communities subject to questioning that their White counterparts are not [MPCAG/43 - INQ000401135]. Such incidences break the necessary relationship of trust between patient and healthcare provider, with the potential for negative health outcomes for the patient and knock-on implications for public health.

101. Medact outline anecdotal evidence suggesting that patients were selectively asked for ID based on their appearance and that it was common for overseas visitor managers to scan patient lists for names that 'look foreign', a claim that is supported by a number of stories that came to light in the media [MPCAG/44 - INQ000137478]. One respondent reported a case where a man receiving treatment for Covid-19, and having only just been discharged from the ICU, was sent

[8] The findings were based on responses received from 70 representatives of 53 different organisations. Medact *Patients Not Passports – Migrants' Access to Healthcare During the Coronavirus Crisis* June 2020 p2 and section 2.3.

a letter asking him to prove his immigration status. The man was a British citizen, and the family felt that they had been racially profiled [MPCAG/42 - INQ000137488].

102. In the same report, Medact further highlighted evidence that people from BAME backgrounds experience different approaches to care and different treatment outcomes compared to white patients [MPCAG/42 - INQ000137488]. The systemic biases that disadvantage people from BAME backgrounds have been made worse by the NHS charging regulations, leading to increasing health inequality and worse outcomes for BAME patients.

103. The causative role played by the Hostile Environment was recognised by Public Health England in its analysis of the factors that led to disproportionate impact of the Covid-19 crisis on BAME communities [MPCAG/45 - INQ000176354]. Medact's research also uncovered that a fear of contracting Covid-19 while accessing healthcare, leading to an avoidance of services, was exacerbated by fears of discriminatory treatment and the disproportionate number of migrant and BAME Covid-19 deaths [MPCAG/42 - INQ000137488].

104. Despite the Covid-19 vaccine and therapeutics being exempt from charge under the Charging Regulations, inadequate steps were taken by the Government to:

    i. undertake targeted information campaigns within the migrant community to overcome and remedy the complexity and confusion of the NHS charging regime to build trust and confidence for migrants accessing Covid services,

    ii. provide clear reassurance to counteract the long-standing fear and anxiety within the migrant community of charges for medical services (often erroneously applied notwithstanding an existing exemption) and the consequences of such charges on future immigration applications,

    iii. address structural racism linked to the charging regime that deterred migrants and the wider BAME community from accessing services during the pandemic.

105. Ultimately, the Government's failure and/or refusal to properly identify that to rebuild trust, the entire NHS charging regime needed to be repealed, meant that merely including Covid-19 as an exemption in law did nothing to increase migrant uptake of the vaccination or improve access to therapeutics. This was a critical failing.

106. To this day, there remains considerable confusion amongst migrant communities in relation to accessing therapeutics for treatment of Covid-19.

107. Although initial testing and treatment for Covid-19 is exempt from the charging regime, secondary care for *"conditions or complications which arise from the initial COVID-19 infection, including long COVID [and] any co-existing conditions a patient may have"* remain fully

chargeable under the charging regime (unless the individual falls to be exempted under one of the other categories detailed above) [MPCAG/46 - INQ000401138].

108. Fear of being charged for secondary care arising from Covid-19 remains a significant barrier to migrants accessing therapeutics in the first place.

109. This on-going barrier is particularly important for the Inquiry to note when considering the high rates of Covid-19 related health complications for ethnic minorities. Studies have considered the possibility of ethnic differences in the expression of the host receptor for SARS-CoV-2, and the risk of both acute kidney injury and cardiac complications because of a higher prevalence of cardiovascular risk factors in ethnic minority populations [MPCAG/47 - INQ000401139]. For example, compared with white British individuals over 60 years of age, Bangladeshis are more than 60% more likely to have long-term health conditions that make them particularly vulnerable to severe infections, including Covid-19 [MPCAG/48 - INQ000401140].

NHS data sharing with the Home Office.

110. Regulation 3A of the Charging Regulations requires NHS bodies to record the immigration and charging status of patients.

111. NHS Trusts are instructed to inform the Home Office of any unpaid debt owed by an overseas visitor [MPCAG/49 - INQ000401141]. In accordance with DHSC guidance, NHS Trusts are required to report to the Home Office the personal details of any patient with a debt of more than £500 that has been outstanding for more than 2 months with no payment plan in place [MPCAG/31 - INQ000401122].

112. NHS Trusts are empowered to undertake immigration checks on patients by contacting the Home Office to request information on an individual's immigration status to determine exemption from the charging regime [MPCAG/50 - INQ000401143].

113. In 2016 the Home Office signed a Memorandum of Understanding with NHS Digital and the Department of Health (that came into effect on 1 January 2017), formalising a practice that was already taking place on an ad hoc basis [MPCAG/51 INQ000401144]. This Memorandum set out the permissible circumstances in which the Home Office could request patient data from NHS Digital relating to "immigration offenders" for the purposes of immigration control and immigration enforcement.

114. In April 2018 the Commons Select Committee on Health and Social Care heavily criticised the Memorandum. The Committee underscored the fundamental ethical principle that healthcare data should only be shared with law enforcement for the purposes of serious crime and that NHS Digital's decision to routinely share information with the Home Office, to a lower threshold, was entirely inappropriate and contrary to the best interests of patients [MPCAG/51 - INQ000401144].

115. This Memorandum was withdrawn in 2018 following litigation, but data sharing related to the charging regime nonetheless linked to immigration action persists.

116. Data sharing is a significant deterrent for migrants seeking medical services, particularly undocumented migrant who fear that it will lead to detention and removal. It has created a deep-rooted culture of mistrust and suspicion towards the NHS.

117. This fear and mistrust extended to accessing vaccines and therapeutics during the pandemic.

118. There was no firewall implemented by the NHS and the Home Office during the pandemic to allay fears of immigration enforcement action being pursued after an individual had accessed a Covid-19 vaccine or therapeutic services.

119. The Government took no active steps to ensure that any data provided by someone receiving the Covid-19 vaccine was not passed to the Home Office by the NHS or by NHS Digital. Instead, the government passively relied on the presumption that since no NHS service would raise a bill for a Covid-19 vaccine, there would be no outstanding debts as a result and consequently nothing to report to the Home Office.

120. This failed to address the wider and valid concerns amongst migrants that significantly impeded vaccine uptake.

The 'No Recourse to Public Funds' condition (NRPF).

121. NRPF is a condition attached to an individual's immigration visa barring access to social welfare benefits including Universal Credit, Housing Benefit, Child Benefit, Working Tax Credit, Disability Allowance, and Income-Based Job Seekers' Allowance.

122. NRPF is applied to most migrants unless they have permanent settled status (Indefinite Leave to Remain) or have naturalised as a British citizen.

123. According to analysis undertaken by the Migration Observatory at the University of Oxford, at the end of 2022 there were 2.58 million people in the UK who held valid visa types that are typically subject to the NRPF condition, estimated to have increased from 1.48 million people at the end of 2020 [MPCAG/110a - INQ000508361]. This figure does not include undocumented migrants who are in the UK without valid leave, and are therefore also subject to the NRPF condition.

124. Evidence shows that NRPF disproportionately impacts single parents, low-income families, and Black and Brown communities [MPCAG/54 - INQ000281061].

125. In practical terms, NRPF means that migrants are barred from accessing financial support if they lose their employment through ill health.

126. The Coronavirus Job Retention (Furlough) Scheme and Universal Credit was not available to migrants with NRPF visa conditions and undocumented people therefore individuals were forced to continue to work throughout the pandemic to avoid destitution or loss of employment, placing them at increased risk of exposure to the virus and increasing the risk of them spreading the virus to the detriment of wider public health.

127. The NRPF condition directly undermined public health messaging urging people to stay at home if Covid-19 symptoms were present as migrants subject to NRPF had no alternative access to financial support in order to survive. JCWI's research corroborates that NRPF is a public health risk. According to their research, migrants with NRPF were 52% more likely to say that it was not possible for them or a member of their household to safely self-isolate in their home due to overcrowding [MPCAG/55 - INQ000142284].

128. Furthermore, a significant proportion of migrants who are subject to NRPF will also fall within the scope of the NHS charging regime. The impact of the interplay between these two policies creates a socioeconomic vulnerability meaning that migrants who are at increased risk of financial hardship without any social welfare safety net experienced heightened fear of accessing medical services, including the Covid-19 vaccine and therapeutics, for fear and/or confusion that this counts either as public funds from which they are barred, or will otherwise result in NHS debt that they may struggle to repay, and/or that may result in information being shared for immigration enforcement action by the Home Office.

Cumulative impact of Hostile Environment policies

129. The significance of these Hostile Environment policies is not limited to their direct impact, for instance in the denial of medical care to migrants not able to pay the relevant charges. Their harmful remit is wide and interconnected, impacting a significant proportion of the migrant community, not limited to undocumented migrants.

130. Cumulatively, and alongside other structural factors discussed below, they have created an environment in which many migrants, whether lawfully in the UK or not, feel unable to trust not just immigration government officials, but also healthcare workers, to whom aspects of immigration control are now effectively devolved.

131. Migrants, when surveyed, have consistently cited historical mistrust of health services, fear of charges and debt, and fear of data sharing and the threat of immigration enforcement action as reasons for avoiding seeking care during the Covid-19 pandemic [MPCAG/56 - INQ000235290].

132. Furthermore, these policies, reinforced by the Government's strong anti-migrant rhetoric, have stoked division, systemic racism and discrimination against both migrants as a class and within communities with a strong migrant presence.

133. Inadequate and insufficient action was taken by the Government to counteract the profound mistrust and structural impediments to accessing healthcare prior to and during the pandemic. For many migrants, the consequence of these barriers (actual or perceived) was that their only recourse to healthcare was through charitable organisations providing medication, treatment and vaccination. The result was individual harm to migrants and unnecessary damage to wider public health.

Barriers to GP registration

134. Migrants in the UK do not live in a vacuum. Daily they experience the wider consequences of anti-migrant rhetoric and Hostile Environment policies designed to exclude and isolate.

135. They experience intersecting socioeconomic and racist barriers and discrimination based on their ethnicity, race, disabilities, language, and immigration status. An example of this is the barriers experienced by migrants in registering with a GP.

136. GP registration is important because it is the gateway to primary care services that ought to be free at the point of access for all, and it is the means through which a migrant is able to obtain an NHS number.

137. While everyone in the UK, regardless of immigration status, is entitled to register with a GP, in reality, GP practices routinely refuse to register one fifth of migrants and refugees as patients [MPCAG/57 - INQ000235276].

138. There is no regulatory requirement to provide proof of identity, address, immigration status, or an NHS number for registration with a GP [MPCAG/58 - INQ000113337]. Under NHS Guidelines, if a patient is unable to produce any supportive documentation but states they reside within the practice boundary, GP practices should accept the registration [MPCAG/59 - INQ000401152].

139. However, the prevalence of refusals by GP practices based on immigration status and lack of paperwork reflects widespread poor implementation of NHS England guidance that wrongfully denies access to some of the most vulnerable migrants.

140. In 2018, DOTW made 2189 registration attempts, of which one fifth, across 990 GP practices, were refused. Almost 60% of the refusals were based on an inability to produce the required paperwork (ID or proof of address) [MPCAG/60 - INQ000401154]. In over 25% of registration attempts, receptionists were also unable to confirm whether individuals could proceed as registered NHS members before consulting with the practice manager. This study exemplifies the prevalence of gatekeeping behaviour by GP practices and the widespread failure to comply with NHS policy guidelines [MPCAG/60 - INQ000401154].

141. As outlined in further detail below, there are an additional two barriers that inhibited migrants from being able to register with a GP or, if registered, prevented them from being able to access primary health care services, including the vaccine, during the pandemic. The first barrier applies to destitute asylum seekers accommodated by the Home Office who operate a policy whereby accommodation-providers are not required to assist residents with GP registration unless there is an obvious or urgent medical need. This resulted in a large proportion of the asylum-seeking population not being able to register with a GP at the commencement or during the pandemic (notwithstanding the subsequent barrier they may encounter of GP practices refusing to register them based on a lack of documentation). The second barrier was caused by the move by GP practices (continued to this day) towards digitalisation and virtual consultations. This exacerbated have existing inequalities in access to health care for many migrants due to digital exclusion and language barriers [MPCAG/15 - INQ000401104].

142. The consequence of GP practices refusing to register migrants, or other barriers preventing registration, is two-fold: i) migrants are erroneously denied access to primary care which further undermines their trust in the NHS and ii) migrants are deprived of an NHS number.

143. The harm caused by this barrier to primary health was amplified during the pandemic.

144. Firstly, those who were refused registration with a GP did not benefit from having their pre-existing medical conditions recorded on the primary health care system. It was from data recorded in GP records that individuals were assessed and identified as being potentially clinically vulnerable and invited as eligible for early vaccination (if clinically appropriate). Genetic predispositions and pathophysiological differences in the susceptibility or response to infection include an increased risk of admission for acute respiratory tract infections, an increased prevalence of Vitamin D deficiency, increased inflammatory burden, and higher prevalence of cardiovascular risk factors such as insulin resistance and obesity than white populations, all of which are proven risk factors for increased disease severity in Covid-19 [MPCAG/61 - INQ000401155 , MPCAG/62 - INQ000401156]. However, clinically vulnerable migrants who had been denied GP registration were overlooked and remained unvaccinated in the early stages despite suffering from comorbidities that substantially increased their health risk.

145. Secondly, some of those who were refused GP registration (or were deterred from accessing primary care based on NHS data sharing and charging policies) are likely to have had undiagnosed or untreated underlying health conditions that placed them at increased risk of complications from Covid-19. Their lack of awareness of such health conditions, or the lack of treatment for the same, exacerbated the health risk that was compounded by the other barriers preventing early access to the Covid-19 vaccine.

146. Thirdly, the mainstream vaccination booking system (the National Booking System) only enabled those with an NHS number and active GP registration to book appointments. This created a direct barrier to vaccine access for a significant proportion of migrants both documented and undocumented for the reasons set out above.

147. Prior to the pandemic the Government was fully aware of barriers to GP registration and thus barriers to obtaining an NHS experienced by migrants. Despite being aware of this, the vaccination model chosen and implemented by the Government was predicated on having an NHS number which automatically excluded large numbers of migrants. This was no apparent consideration or planning in place to address the specific access issues for these communities.

Structural and institutional racism and discrimination

148. Immigration control in the UK is underpinned by racial hierarchy that was created during colonialisation and the British Empire. From 1962 and 1968 the right to access British citizenship was, for the first time, explicitly demarcated by race [MPCAG/63 - INQ000409588]. Successive and increasingly restrictive and punitive immigration laws and policies, and the UK's treatment of migrants, have become explicitly more racialised and racist.

149. Exclusionary barriers created by Hostile Environment policies, that stoke racial division, must be considered alongside the wider and structural racism, discrimination and prejudice experienced by all ethnic minorities in the UK.

150. Many migrants are from racially minoritised communities. Even before the pandemic, they faced institutional and structural racism when accessing health care. This was exacerbated during the pandemic.

151. There is no clear, standard definition of structural racism. The European Network Against Racism defines it as a product of a system in which public policies, institutional practices, cultural representations, and other norms work in various ways to perpetuate racial inequality as a feature of the social, economic and political system [MPCAG/64 - INQ000401157].

152. It has been calculated that from the ten major government reports and reviews on racial inequality, from the 1999 Macpherson Report into the death of Stephen Lawrence up to the Windrush Lessons Learned Review in 2020, a total of 375 recommendations have been made to address this, most of which remain outstanding [MPCAG/65 INQ000401158].

153. The UK Government's most recent Commission on Race and Ethnic Disparities, chaired Dr Tony Sewell, published its report in 2021 (more commonly referred to as 'the Sewell Report') [MPCAG/66 - INQ000089803]. The report was widely and heavily criticised for fundamentally ignoring or diminishing evidence of on-going institutional and structural racism in the UK.

154. The intersection of central characteristics within the migrant community, for example, ethnicity, race, immigration status, disability, and language barriers, particularly those protected under the Equality Act 2010, must be taken into account by the Inquiry when examining barriers that inhibited access to vaccines and therapeutics by migrants.

155. For instance, the NHS charging regime has enhanced structural racism in healthcare. Medact has reported on anecdotal evidence of patients being selectively asked ID based on their appearance and for overseas visitor managers to scan patient lists for names that 'look foreign' (a claim also reported in the media).

156. Research reveals that, long before Covid-19, people from BAME backgrounds experience different approaches to care and different treatment outcomes compared to white patients [MPCAG/67 - INQ000401160, MPCAG/68 - INQ000401161].

157. Further, the rigid approach by many GP practices during the pandemic to digitalisation and virtual consultations further indirectly discriminated against many migrants who experienced technological, language and communication barriers that prevented them from accessing the support they required.

Socioeconomic barriers

158. The impact of socioeconomic inequality on health outcomes during the pandemic cannot be underestimated.

159. It has been reported that 1 in 3 premature deaths in England between 2003 and 2018 could be attributed to the effects of socioeconomic inequality [MPCAG/69 - INQ000401162].

160. These inequalities persisted and were amplified during the pandemic.

161. Socioeconomic barriers relevant to the migrant community's ability to access vaccines and therapeutics during the pandemic included poverty, digital exclusion, social isolation, poor transport, and language barriers.

162. As detailed above, digital exclusion linked to poverty acted as a significant barrier for some migrants being able to access the Covid-19 vaccine and primary care services as well as health information and guidance. It is reported that digital exclusion is most pronounced in older minority ethnic group adults (+ 55 years), the group which was also most at risk of poor Covid-19 health outcomes [MPCAG/70 - INQ000401164]. Yet despite this, access to vaccination bookings in the early pandemic had a significant digital element despite this inhibiting access for the most at-risk group. This barrier was amplified as a result of the digitalisation of GP services resulting in some migrants being doubly excluded from being able to access healthcare support related to covid during the pandemic.

163. Language barriers experienced by migrant communities contributed to their digital exclusion and inability to book a vaccine appointment. It has been reported that the combination of online forms only ever being in English and lockdowns reducing contact with friends who previously assisted with translation negatively impacted on many migrants being able to understand health information and messaging [MPCAG/15 - INQ000401104].

164. More widely, the Home Office have exponentially increased the fees for immigration applications as a profit-making process year on year since 2003, when previously they were largely fee free.[9] Without any financial safety net available when employment was lost during the pandemic, as a result of the NRPF condition, increasing numbers of migrants were unable to pay to seek to lawfully extend their visas, rendering them undocumented, and subject to the full force of the Hostile Environment which in turn prevented and deterred access to healthcare and vaccination during the pandemic, compounding the harm to them.

165. DOTWUK research indicates that the public cost of transport was in some cases prohibitive to accessing healthcare during the pandemic. In their report they highlight that the suspension of mobile clinics and outreach services made physically accessing healthcare a challenge for some people, and that the cost of transport was a barrier especially for those experiencing deprivation [MPCAG/71 - INQ000235286].

Hostile decision-making about asylum accommodation

166. From September 2020 the Home Office (through its contracted accommodation provider, Clearsprings Ready Homes Ltd) started to accommodate asylum seekers in unused military barracks in Penally, Pembrokeshire and Napier, Folkestone. The suitability and safety of these overcrowded and poor-quality accommodation sites have been widely and heavily criticised [MPCAG/107 - INQ000401098].

167. Despite Government guidance to accommodation providers recommending single rooms with en-suite bathrooms to enable self-isolation to reduce the risk of Covid spreading, these military barracks were overcrowded with shared bathrooms and up to 20 individuals sleeping in a shared dormitory [MPCAG/5 - INQ000401142].

168. In June 2021 the Administrative Court found that the Home Office's use of former military barracks was unlawful. It was held that the decision to use the barracks fundamentally departed from the advice of Public Health England and that the accommodation failed to ensure a standard of living adequate for health [MPCAG/72 - INQ000401166].

169. Further, the location of these barracks was not conducive to facilitating access for residents to vaccinations and medical care. They were in remote and isolated areas which significant restricted the liberty of the residents, akin to detention.

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[9] House of Commons Library *UK Immigration Fees* 14 February 2024: "*Until 2003, the UK charged nothing at all for visa extensions, work permits and settlement. Fees for initial visas and citizenship were relatively modest. A student visa cost £36. The Blair Government began charging above the processing cost in order to fund wider immigration activities. Later governments continued that process and added the health surcharge (2015) and employer levy (2017). Government income from immigration and nationality fees rose from £184 million in 2003 to £2,200 million in 2022, not including another £1,700 million in health surcharge and £600 million in employer levies*" **[MPCAG/70a - INQ000474441]**

170. This is a further example of Hostile Environment decision-making designed to make the situation of asylum-seekers and their access to healthcare during the pandemic as difficult as possible at the expense of wider public health interests.

Inadequate government planning and responsiveness to remove or overcome these barriers

171. MPCAG became increasingly alarmed by the Government's inadequate preparedness and response to the pandemic, and its poor communication strategies concerning at-risk individuals and vulnerable cohorts such as migrants.

172. The cumulative consequence of the factors discussed above was that the 'starting point' at the commencement of the pandemic was a very low level of trust between the Government and the NHS and migrant communities.

173. Decades of oppressive and cruel measures, racism and vilification have bred suspicion and mistrust amongst the migrant community in all their dealings with the state and state institutions, regardless of whether they had lawful immigration status to be in the UK.

174. Extension of the 'Hostile Environment' into healthcare transferred distrust to the NHS.

175. Furthermore, immigration laws and policies are vastly complex and opaque. Understanding the laws and regulations relevant to healthcare access is beyond the reach of most non-specialist lawyers, but particularly for migrants to whom they apply.

176. It was therefore critical for the Government to have taken purposeful, effective, direct, and well-communicated action to dismantle and fully remove these pre-existing barriers and inequalities to ensure access to vaccines and therapeutics for migrants during the pandemic.

177. This simply did not happen.

178. The Government, and in particular the Home Office, failed to take the necessary action to protect the wider migrant community during the pandemic, including by facilitating access to vaccines and therapeutics, thereby increasing the risk to those communities and creating a wider risk to public health.

Failure to take direct action to remove barriers

179. MPCAG organisations and many more organisations repeatedly put forward clear recommendations to the Government on how to remove the most influential and harmful barriers to vaccines and therapeutics for migrants.

180. This included, as a fundamental starting point, suspending the Hostile Environment policies such as the NHS charging regime, data sharing between the NHS and the Home Office and the NRPF condition and, to ensure the effectiveness of this action, to implement an information campaign amongst NHS staff and within migrant communities to raise awareness of these changes.

181. Further recommendations were made to suspend immigration enforcement and visa requirements to prevent individuals from becoming undocumented during the pandemic for example, due to loss of employment through no fault of their own.

182. These actions would have made substantial inroads into addressing the practical barriers, racism and fear migrant communities experience when engaging with healthcare services.

183. These changes were within the power of the Government to implement.

184. During the pandemic the Government was taking exceptional and unprecedented steps to financially protect and support the broader population at large.

185. Yet persistently the Government refused and/or failed to consider or implement these recommendations to safeguard migrants and their health, based on the prioritisation of political objectives above wider public health in general. As a direct result, migrants died and/or suffered adverse health consequences.

Inadequate government identification of and responsiveness to vulnerable migrants

186. Chronically low rates of GP registration amongst migrants, that were known to the Government, not only prevented access to an NHS number (the vaccine-related consequences of which are detailed above), but also caused a significant number of migrants to have undiagnosed comorbidities that placed them at heightened health risk when faced with the Covid virus.

187. The Government's vaccine prioritisation policy was based primarily on two factors: age and pre-existing health conditions. For example, priority vaccine group 4 included clinically extremely vulnerable individuals and group 6 included at-risk individuals based on clinical conditions [MPCAG/73 - INQ000302492].[10]

[10] Listed as: a blood cancer, diabetes, dementia, a heart problem a chest complaint or breathing difficulties, a kidney disease, a liver disease, lowered immunity due to disease or treatment, rheumatoid arthritis, lupus or psoriasis, have had an organ transplant, had a stroke or a transient ischaemic attack, a neurological or muscle wasting condition, a severe or profound learning disability, a problem with your spleen, are seriously overweight, and are living with a severe mental illness.

188. Barriers to GP registration led to pre-existing health conditions not being recorded on GP records that in turn resulted in clinically vulnerable migrants being overlooked for early vaccination.

189. Despite the Government being fully aware of barriers to GP registration for migrants, no alternative steps were implemented to identify vulnerable migrants who might be eligible for early vaccination either through outreach work or through implementing a self-identification mechanism for those who were not registered with a GP.

190. SAGE's own advice and analysis identified from previous vaccination programmes that there is a lower vaccine uptake rate amongst all ethnic minority populations compared to the White population [MPCAG/74 - INQ000250215]. Certain migrants were therefore already identified as a vulnerable cohort. Yet these lessons were not adequately applied to outreach and facilitation of migrants accessing the Covid-19 vaccine.

191. Steps were not taken to remove barriers to GP registration, to address digital exclusion, or to rebuild trust by addressing the consequences of the NHS charging and data sharing regimes. Vulnerable migrants were, as a result, excluded and overlooked.

Poor communication strategies – lack of clear and inclusive messaging

192. There was a lack of information and public health messaging targeted at migrants during the pandemic. The Government's communication failings created yet a further barrier to vaccine uptake within the migrant community.

193. For example:

i. The televised press conferences, which were a major source of information being announced by the Government during the pandemic, were in English which rendered them difficult to follow to non-native speakers or those without any English at all.

ii. There was considerable misinformation circulating amongst migrant communities, who turned to alternative and sometimes unreliable sources, that was not targeted by government communications to improve health literacy or trust. Efforts by grassroots organisations to address misinformation was not supported by funding or provision from the Government.

iii. There was concern within the migrant communities that they were not being included or represented in clinical vaccine trials. The Government messaging failed to address or allay these fears to encourage vaccine uptake.

194. Clear, strong, and persuasive Government messaging directed specifically at the migrant community during the pandemic was crucial to undo some of the deep-rooted harm, fear and mistrust caused by decades of Hostile Environment policies designed to discourage migrants from interacting with healthcare services and health authorities.

195. Instead of taking responsibility for this, the Government overly relied on community groups and overstretched, under resourced grassroots organisations to spread messaging about the Covid-19 vaccine among migrant communities, often without funding available, without which public health information would not have been shared in community spaces and in diverse languages.

196. It was not until 27 April 2020, a month after the commencement of the first national lockdown and three months after the first Covid-19 infections were identified in the UK, that the DHSC issued translated advice for migrants about their entitlement to access healthcare during the crisis [MPCAG/75 - INQ000401169]. When the Government did start translating public health guidance in late March 2020, often the information was out of date by the time it was made public as it took them 2 weeks to do each translation. Timely information was critical given the constantly changing information on Covid-19.

197. The Government initially made information available in only 9 languages, eventually reaching 15 languages. This was an incredibly slow pace. By comparison, at this time DOTWUK had information translated in up to 64 languages (translated within 2 days of the government publishing information in English and regularly updated as the Government advice changed). Prior to this, the Government had been relying on translated resources provided by civil society organisations, in particular DOTWUK [MPCAG/76 - INQ000401170]. However, by the 2021 vaccine campaign the Government had managed to translate information in 26 languages.

198. In June 2020, Medact, along with Migrants Organise, and the New Economics Foundation, conducted research into the healthcare inequalities faced by BAME and migrant communities [MPCAG/42 - INQ000137488]. The findings of this survey highlighted the inadequacy of government messaging and communication to counteract Hostile Environment barriers to the healthcare services, socioeconomic barriers based on language and structural racism in how migrants are treated by health bodies:

    i. Several respondents reported that, in contravention of NHS England guidance, migrants were frequently asked to pay for or provide their own interpretation services [MPCAG/77 - INQ000401171].

    ii. 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.

    iii. 56% of respondents had not seen any information from public bodies raising awareness of migrants' rights to healthcare during the coronavirus crisis.

iv. 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.

199. Medact's findings clearly demonstrated that these attempts by the Government to mitigate the deterrent effect of the Hostile Environment during coronavirus were inadequate. Information was not adequately publicised. Merely enacting legal charging exemptions for the Covid vaccine was not insufficient to create or rebuild trust.

200. During the relevant period many health services were being administered online or over the phone, including all health information and guidance. GP registration and booking had become entirely digitalised. Many migrants faced digital exclusions and language barriers, which made accessing primary health services in this way extremely difficult.

201. Digital exclusion is particularly prevalent for migrants who are destitute or experience financial hardship either due to being undocumented, being in low-paid work, being subject to the NRPF condition, or being an asylum seeker reliant on the Home Office financial support of only £37.50 a week. These migrants had extremely limited funds to top up their mobile phones or buy additional data. Moreover, community centres, libraries, and support organisations where internet services were previously available for free had been closed as a result of the lockdowns. The information was never distributed in paper format, nor in a diverse range of languages to areas known to have high migrant populations. This barrier was not considered or addressed by the Government.

202. The Government failed to take adequate steps to address long-standing barriers to GP registration by migrants (that inhibited vaccine uptake) through language-specific public information campaigns aimed at clarifying and confirming to both the migrant community and GP practices that primary care is free for all, that proof of ID or address is not required for registration and that GP registration was crucial to facilitate access to the vaccine. The Government failed to provide necessary interpretation services or funding to facilitate migrants' communication with GP practices in order to register and/or make and attend appointments.

203. Despite there being some examples of good practice with NHS England consulting community organisations for advice on how to reach migrant communities, and subsequently provided clear statements about accessing the vaccine e.g. around not needing to share immigration status or nationality, this was never replicated by central government in a uniform and consistent manner rolled out across the UK.

Inadequate access to vaccines and therapeutics for destitute asylum seekers in Home Office accommodation

204. The healthcare barriers and heightened risk of harm faced by destitute asylum-seekers accommodate by the Home Office were two-fold; firstly in experiencing difficulties in registering with a GP and obtaining an NHS number to access a vaccine and secondly as a result of the

Government failing to identify highly populated accommodation sites as being "high risk" and therefore to prioritise as eligible for early vaccination.

Barriers to GP registration

205. Destitute asylum-seekers who were accommodated in Home Office accommodation during the pandemic faced particular challenges accessing an NHS number. This was due to Home Office policy of not registering people in asylum dispersal or contingency accommodation with a GP [MPCAG/78 - INQ000401172].

206. Based on the presumption that people seeking asylum will only be accommodated in initial or contingency accommodation for a maximum of three weeks, this Home Office policy did not require accommodation providers to support or signpost residents to NHS services (i.e. to register with a GP) unless a person has an *"obvious and urgent health care requirement"*. Prior to and during the pandemic, people were accommodated in initial or contingency accommodation for significantly longer than the three-week target. During the pandemic this increased to years as a result of the increased backlog of outstanding asylum applications.[11]

207. This means that those living in asylum dispersal or contingency accommodation did not have an NHS number or active GP registration and hence would not have been invited for a vaccination appointment when eligible, or would have faced difficulties in booking a vaccine appointment.

208. The Home Office has persistently failed to make the necessary policy amendments to act on recommendations that have been made by two separate bodies; firstly by the Home Affairs Select Committee, and secondly by the National Asylum Seeker Health Steering Group.

209. DOTW raised the issue of barriers to GP registration for Home Office-accommodated asylum seekers in written evidence before the Home Affairs Select Committee inquiry on Home Office preparedness for the pandemic [MPCAG/79 - INQ000142182]. The Select Committee's report recommended that when service users remain in initial accommodation for more than three weeks, accommodation providers should ensure that all their residents are linked up to primary and secondary health provision [MPCAG/80 - INQ000075357]. DOTW called on the Home Office to ensure that this change was made, if necessary, by a variation to the Asylum Accommodation and Support Statement of Requirements, the document that outlined accommodation provider's responsibility to facilitate access to medical care. DOTW also requested that the Home Office ensure necessary funding was secured for affected statutory health services related to this change.

210. The Government has failed and/or refused to act on the Committee's recommendation and, to date, has not changed the impugned policy.

[11] The Migration Observatory *The UK's asylum backlog* 3 May 2024 **[MPCAG/78a - INQ000474438]**

211. In its response to the Committee's report dated 28 July 2020, the Government confirmed on 13 November 2020 that asylum accommodation providers would continue to take an 'as and when needed' approach to GP registration that continues to leave a significant number of the destitute asylum-seeking population unregistered with a GP and therefore, critically, without an NHS number [MPCAG/81 - INQ000075356]. The Government considers the existing process to be adequate, despite the Select Committee concluding otherwise.

212. A National Asylum Seeker Health Steering Group was established in 2021 which was chaired by Public Health England and the Home Office and included various stakeholders, including DOTW. An Access to Healthcare sub-group was responsible for work relating to 10 recommendations, one of which required NHS England and the Home Office to agree a standard and clearly defined route to GP registration and health access. The subgroup recommended that the Asylum Accommodation and Support Statement of Requirements be amended to require asylum accommodation providers to support all residents to register with a GP as a permanent patient.

213. Again, this recommendation was never implemented by the Home Office.

Failure to identify large-scale asylum accommodation sites as high-risk.

214. By the end of 2021 there were 79,737 asylum seekers being accommodated by the Home Office. This rose to 105,522 asylum seekers by the end of 2022 [MPCAG/22 - INQ000401112, MPCAG/23 - INQ000401113].

215. NHS England recognised that asylum accommodation settings including contingency hotels and immigration removal centres were high risk settings because *"these settings often have new people regularly moving in, meaning COVID-19 is easy to bring in. They also often share accommodation and facilities, which are often crowded, so if COVID-19 is brought in, it can spread quickly. These settings are also more likely to have people with poor health living in them, and some people with certain medical conditions may get very ill with COVID-19."* [MPCAG/82 - INQ000401177]

216. Despite this, there was a clear failure by the Government to prioritise asylum accommodation sites as 'high risk' and eligible for early vaccines and targeted vaccine information outreach.

217. For homeless people and rough sleepers experiencing similar barriers to primary health care access such as lack of NHS numbers, challenges with social distancing and high rates of undiagnosed comorbidity, the Government accepted JCWI's recommendation that local vaccination teams could offer access to a vaccine alongside cohort 6 in phase 1 of the vaccine deployment programme [MPCAG/83 - INQ000354434]. By comparison, no similar planning or provision was made for migrants. This was a significant missed opportunity in removing barriers to increase vaccine uptake within the asylum-seeking population.

218. Instead, it is reported that local vaccination teams that did decide to prioritise asylum accommodation settings were criticised by government and regional health leaders [MPCAG/84 - INQ000401179].

219. Voluntary sector organisations reported particularly low levels of vaccination uptake among asylum seekers in hotels [MPCAG/56 - INQ000235290].

220. In January 2021, a COVID-19 outbreak occurred at a former military barracks in Kent that the Home Office was using to accommodate roughly 400 asylum-seekers, some in shared rooms sleeping 28 men [MPCAG/85 - INQ000401180]. It was reported that by the end of the month, over half of residents had been infected by the virus.

Failure to implement a mechanism to enable visa extension

221. For migrants on fixed-term visas that expired during the pandemic, their inability to travel or leave the UK during lockdowns rendered them in breach and deemed to be 'undocumented' / 'overstayers', subject to the full force of the Hostile Environment policies, through no fault of their own.

222. Whilst the Home Office's 'Exceptional Assurance' scheme, introduced on 24 March 2020, offered short-term assurance to some migrants that overstaying a visa for this reason would not lead to adverse immigration consequences, it did not amount to a proper process by which such migrants could apply to extend their visas.

223. The 'Exceptional Assurance' scheme fundamentally lacked substance and certainty. It was not a formal concession introduced into the Immigration Rules. Neither did it create a statutory or enforceable right.

224. Reliance on the exercise of a discretion, sent via email as and when the Home Office responded, was wholly insufficient to reassure and provide confidence to affected migrants that their rights were protected. Without enforceable legal rights, migrants lacked confidence that the Hostile Environment policies would not apply to them given their new status of being undocumented or so-called "overstayers." Those who sought to benefit from the concession did not have any evidence of their status which could be relied upon.

225. To put this into context, health workers such as the 200,000 Filipinos in the UK in 2020 who made up the third largest nationality working in the NHS after Britons and Indians [MPCAG/19 - INQ000401108] were liable to have their visas expire during lockdowns without proper recourse to a process that provided a legally enforceable guarantee that their right to remain in the UK and right to work was protected.

226. Similarly, migrant domestic workers who are granted a fixed term 6-month visa that is not extendable, were left in an exceptionally precarious situation. These migrants are often isolated

in private homes and exposed to higher risk of exploitation that was amplified after becoming undocumented. Fear of immigration enforcement action against undocumented migrants and the absence of a clear and accessible mechanism to apply to extend visas and for statutory leave to be automatically extended created a barrier to accessing vaccines and healthcare during the pandemic, in addition to the inability to leave their employers' house, as is the case for migrant domestic workers who are exploited by the employers they live with.

E: IMPACT OF THESE BARRIERS DURING THE PANDEMIC

227. Policies that force some communities to avoid seeking healthcare have negative implications for public health in ordinary times, but during the course of a global pandemic their effects can be catastrophic. The human cost of the barriers and impediments to vaccines and therapeutics identified above is illustrated by the following case studies that reflect MPCAG's wider experiences during the pandemic, either in the words of the migrants themselves, or from the organisations that serve them:

228. ***Case study one:*** In April 2020, a Filipino man died at home with suspected coronavirus. He had lived and worked undocumented in the UK with his wife for more than 10 years but was afraid to go to hospital for fear of incurring debts he could not repay and being reported to immigration enforcement. He suffered from Covid symptoms for two weeks before he died [MPCAG/42 - INQ000137488].

229. ***Case study two:*** Abdullah is a Syrian national from Raqqa, who fled Syria with his brother when his hometown became a target of the Assad regime. The brothers experienced a long journey to the UK, where they arrived in 2020 and were separated. After lodging an asylum claim, Abdullah was moved to Napier barracks at the end of September 2020. He was housed in a block with 28 others, and became very concerned about the poor hygiene conditions and lack of Covid-19 safety measures. When another person on the block contracted Covid-19, Abdullah went on hunger strike to protest the failure of staff to put appropriate Covid safety measures in place. Abdullah asked for the block to be cleaned, or for cleaning products to be provided. Not only were both requests were refused, but he was told by barracks staff that his behaviour would harm his asylum claim [MPCAG/86 - INQ000142279].

230. ***Case study three:*** Despite government guidance stating that Maria would not need ID to receive her vaccine, when she went to the vaccine centre she was treated in a discriminatory way, questioned about her identity and asked to demonstrate proof of ID: "I said, 'why? Is it because I'm brown that you need to ask me that? That is so not good, it's so unfair. It looks like you're racist!' It looks like I've been humiliated because of my colour... Because since we came here, we are all humiliated, and then you need to make yourselves safe by taking the vaccine, and still there it looks so unfair to treat people like that" – Maria [MPCAG/87 - INQ000401182]

231. ***Case study four:*** A man who had previously been homeless and had his asylum claim refused suffered from undiagnosed diabetes. He did not think he could go to the doctors as he did not

have status. Because he did not receive treatment, he went blind for 6 months [MPCAG/42 - INQ000137488].

232. ***Case study five:*** Amani came to the UK in 2020 from Sudan, where he was forced to leave his business and family, including six children, in order to seek safety. Amani experienced a long and difficult journey to the UK. He was enslaved for several months in Libya and nearly lost his life attempting to escape. These experiences, on top of the torture to which he was subjected in Sudan, left Amani with serious mental health issues, as well as chest pain and headaches. After being released from a period of immigration detention, Amani, who speaks no English and has no family or community connections in the UK, was accommodated in a hotel on the outskirts of London. When he was dropped off at his hotel, he was distressed and desperate to see a doctor, but had no idea where to find one. The Home Office offers no local support or advice in hotel accommodation and no welfare assessment is carried out. Even with the assistance of a JCWI support worker, it took several weeks for Amani to successfully locate and register with a local GP. In the meantime, JCWI covered the transport costs for Amani to attend his local Accident & Emergency department [MPCAG/86 - INQ000142279].

F: ACTION TAKEN BY MPCAG TO COUNTERACT THE IDENTIFIED BARRIERS

233. Individually and collectively MPCAG organisations took repeated and exhaustive steps not only to alert the Government and health bodies to the barriers preventing migrants' access to vaccines and therapeutic services, but also to identify the specific action required to remove these barriers in the interests of wider public health.

234. Repeatedly these efforts were met with no substantive response and/or no action taken.

235. The MPCAG all shouldered significant public health responsibilities during the pandemic. This was not a unique experience, but part of a wider issue where front-line charities were forced to fill the role of the State due to a decade of austerity measures and Hostile Environment policies that isolated, excluded and marginalised vulnerable groups.

236. Despite the Government stating that the vaccine was available to everyone for free, without immigration checks or the need for an NHS number or GP registration, this alone was insufficient to counter the pre-existing barriers. The fear of being charged for NHS services and /or fear of immigration enforcement within the migrant community runs deep, which increased, exponentially, the risk that migrant communities, particularly those with no formal immigration status, would go unvaccinated.

237. The overwhelming majority of individuals that MPCAG represent come from ethnic minority and racialised backgrounds, with many experiencing additional vulnerability and marginalisation due to factors such as destitution, mental health challenges, or social isolation. Throughout the pandemic, MPCAG were compelled to extend their support even further to

meet the needs of migrants and undocumented people who were worried about accessing healthcare and vaccinations [MPCAG/87 - INQ000401182].

DOTWUK

238. DOTWUK underwent significant adaptations and expansions in their service to aid refugees and migrants facing challenges in accessing NHS services during the pandemic. As the primary healthcare systems struggled to cope with the overwhelming impact of Covid-19, DOTWUK augmented their healthcare capacity.

239. DOTWUK played a crucial role in assisting migrants and refugees in accessing the vaccine by running vaccination clinics in London and supporting people to obtain an NHS number in order to book a vaccine appointment.

240. They provided information in over 64 languages on access to vaccines and NHS services, aimed at empowering migrants to overcome the barriers imposed by the Hostile Environment and their advice line signposted people to walk-in vaccine centres. Through community outreach, education, and advocacy efforts, DOTWUK endeavoured to ensure that migrants and refugees understood their rights to access healthcare and encouraged them to seek the vaccine without fear of repercussion.

241. Throughout 2021 and 2022, DOTWUK advocated access to vaccines for all through various campaigns, media work and engagement with government ministers and stakeholders. This included raising awareness for the Vaccines for All ('VFA') call along with other organisations and attending an event with Nadhim Zahawi where DOTWUK and other organisations outlined how the Hostile Environment policies were impacting access to the NHS, including the vaccine.

242. DOTWUK also mapped out the limitations within NHS systems identifying issues surrounding barriers to GP registration and obtaining an NHS number and engaged with national and local government and health systems in England, Scotland, and Wales to address barriers to vaccination appointments. Their media campaigning highlighted that the lack of vaccination walk-in centres resulted in a failure to consider those, such as asylum seekers, who aren't registered with a GP, and the drawbacks with the local authority run outreach programmes [MPCAG/88 - INQ000401183].

243. DOTWUK worked with NHS England and Public Health England to send a letter (in 24 languages) to everyone in asylum accommodation providing information on how to register with a GP and access the vaccine [MPCAG/89 - INQ000235285].

244. NHS England launched an online system to find a local walk-in centre [MPCAG/90 - INQ000401186] and DOTWUK worked with local authorities to ensure walk-in centres did not ask for proof of ID or an NHS number and understood the importance of clearly communicating that patient data would not be shared with the Home Office.

JCWI

245. During the relevant period, JCWI directed the majority of its resources towards addressing urgent issues faced by migrant communities across the UK. JCWI's pandemic response efforts included urgent legal support and advice, assistance with GP registration and accessing vaccines. JCWI also had to provide accessible information on access to healthcare and the Covid vaccine and help people register with GPs.

246. Through the PNP Network, and JCWI's early pandemic research on the barriers migrants faced in accessing care during the pandemic [MPCAG/42 - INQ000137488] JCWI identified in December 2020 / January 2021 that access to the vaccine would be a major issue.

247. JCWI invited organisations to sign on to the Vaccines for All call, to raise awareness and build support for the vaccination roll out to include migrant communities. As part of this work, JCWI set out their rationale and the evidence base for the need to improve access to the vaccines [MPCAG/91 - INQ000401187].

248. JCWI's research revealed that the Government's Covid strategy relied on people being registered with GPs to access vaccinations, and on everyone being willing to go to hospital when sick, and to share personal information with hospital staff without fear of reprisal or future punishment. However, in direct conflict with this, JCWI observed the negative impact of the health system and Government communications having been designed and implemented to discourage migrants from interacting with them.

249. JCWI built on this research by drawing on the experiences of service providers that ran pop-up vaccine clinics, including Kanlungan and DOTWUK. These clinics were well-attended and demonstrated successful cross-sector collaboration. However, they also reflected the level of damage and distrust caused by the Hostile Environment in official healthcare settings. As noted, Kanlungan's clinic which was based in London had people travelling from all over the UK, including as far as Glasgow because they did not feel safe or comfortable accessing the vaccine through the NHS.

250. JCWI published a number of important reports that clearly and unequivocally identified the barriers to vaccines and healthcare for migrants during the pandemic to inform government action.

251. In February 2021, JCWI's report *"Migrants deterred from healthcare during the COVID-19 pandemic"* called for public health to be priotised over immigration control. The report identified the harmful effect of the Hostile Environment policies on vaccine uptake, and referred to data from a recent survey showing that 58% of respondents remain were fearful of accessing healthcare services during the pandemic. Clear recommendations were made for the government to take immediate and direct action to remove these barriers by suspending NHS charging, data sharing and NRPF [MPCAG/92 - INQ000142281].

252. In March 2021 JWCI published a further report "*Migrants with No Recourse to Public Funds' Experiences During the COVID-19 Pandemic*" that analysed the results of a survey of migrants subject to NRPF [MPCAG/55 - INQ000142284]. Almost half of those surveyed (43%) said that they would be scared to access healthcare if they became unwell during the pandemic.

253. In January 2022 JCWI published yet a further report "*'We Also Want to be Safe': Undocumented Migrants Facing Covid in a Hostile Environment*" [MPCAG/87 - INQ000401182]. This report demonstrated the longstanding harm caused by the climate of fear and distrust for migrants within healthcare and broader public life. Albeit a small sample size, all ten people JCWI spoke to were registered with GPs at the start of the pandemic, but several told JCWI that they had not registered for years after arriving in the UK – in some instances as long as 5 or 10 years – due to fear of being deported. In all of these cases interviewees chose not to seek medical attention for a very long time despite having serious health conditions requiring urgent care.

254. In May 2022, JCWI together with the Public Interest Law Centre published a joint report *""Unequal Impacts": How UK immigration law and policy affected migrants' experiences of the Covid-19 pandemic"* [MPCAG/86 - INQ000142279]. The report examined how the Government's decision to maintain Hostile Environment policies during the pandemic recklessly endangered migrants' lives.

Kanlungan

255. At the outset of the pandemic, Kanlungan quickly became aware that an exceptionally high number of Filipino frontline healthcare workers were dying from Covid-19. In response, they initiated a community monitoring project to track deaths amongst the Filipino migrant community. Through monitoring of social media, news coverage, hospital and NHS trust website, and via their network of participatory organisations, they produced early quantitative research of the impact of the pandemic on frontline staff [MPCAG/93 - INQ000235265]. This report called on the Government to end the Hostile Environment measures that were putting the public at risk, called for an amnesty to regularise undocumented migrants and to take adequate steps to communicate the rights of migrants to healthcare during the pandemic.

256. Kanlungan convened focus group discussions with Filipino healthcare workers to produce qualitative research and facilitated a mental health support group for workers who shared experiences of widespread discrimination and harassment leading to disproportionate exposure to Covid-19.

257. Kanlungan found that numerous of their members, particularly those who were undocumented, were concerned about NHS charges and immigration consequences of seeking the vaccination.

258. In addition, they found that their members worried about providing personal contact details to access the vaccination, with the particular fear of being removed, with several undocumented migrants known to Kanlungan having died at home with Covid-19 symptoms. Their members

also described the additional language barrier obstacles when the government was disseminating information about the vaccine to migrants [MPCAG/93 - INQ000235265].

259. Whilst Covid-19 was excluded from the NHS Charging Regulations, Kanlugan's research demonstrated that migrants continued to be deterred from seeking medical care even where medical conditions were excluded, such as treatment for tuberculosis. There was little guidance or effort on the part of local or national government to reach this community. In response, Kanlungan set up vaccination hubs that did not require any registration or documentation to help fill this need. This scheme was later undertaken in conjunction with Hackney Council and then implemented nationally.

260. Kanlungan also undertook the following outreach and lobbying efforts:

    i. Kanlungan set up the first vaccine hubs to allow migrants to access vaccinations without fear of immigration repercussions.

    ii. Kanlungan organised pop-up clinics at a community centre with the NHS Northeast London Trust. The messaging was very clear that this was for undocumented migrants, specifically Filipino, Vietnamese, and Indonesian communities. People travelled from all over the country to get their vaccination with Kanlungan because they did not feel comfortable accessing it at more mainstream services. Whilst Public Health England and NHS England translated some of the information in Filipino community languages, this messaging was not reaching undocumented migrants.

    iii. In response to concerns raised about the inability of members to access Covid information, Kanlungan successfully lobbied for Covid-19 public health information to be translated into Tagalog. As a result, the NHS set up a Filipino language helpline for staff.

    iv. Kanlungan co-founded the Status Now 4 All Network, a campaign calling for all undocumented migrants to be immediately regularised to guarantee access to healthcare, housing, and employment.

261. In November 2021 Kanlungan published a further report *"'A chance to feel safe' and 'Essential and Invisible: Filipino irregular migrants in the UK's ongoing COVID-19 crisis"*. The report highlighted how, in the absence of government support, it had been forced to step in to provide crucial services such as disseminating medical information, holding pop-up vaccination clinics, and delivering basic supplies to those facing destitution [MPCAG/94 - INQ000327678].

Medact

262. In response to growing concerns raised by migrant and health worker members of the Patients Not Passports ('PNP') network and members of Migrants Organise, Medact along with others

including DOTWUK, identified that access to the vaccine would be a major issue for migrants and invited organisations to sign on to the Vaccines for All (VFA) call, to raise awareness and build provision for the vaccination roll out to include migrant communities. This gained support from over 370 organisations, including Local Authorities and medical royal colleges, calling for an end to NHS charging and data-sharing, and a public information campaign to tackle the fear that these policies have created.

263. In June 2020 Medact, alongside Migrants Organise and the New Economics Foundation, published *"Patients Not Passports: Migrants' Access to Healthcare During the Coronavirus Crisis"* [MPCAG/42 - INQ000137488]. The research feeding into this report found that migrants were not coming forward to access healthcare as a result of the Hostile Environment. It was reported that 57% of migrant respondents, including those entitled to free care, had avoided seeking healthcare.

264. In February 2021 Regularise organised a panel event with Nadhim Zahawi, then Vaccine Minister, Kanlungan, whose director, Andrea Martinez spoke and DOTWUK; during which they set out the impact Hostile Environment policies were having on access to NHS care, including the vaccine [MPCAG/95 - INQ000401191]. A few days later the Government announced a 'vaccine amnesty' for undocumented migrants [MPCAG/96 - INQ000401192].

265. Following the launch of VFA, Patients Not Passports campaigners wrote to and organised meetings with key vaccine delivery stakeholders in their communities, most often local councillors, and public health officials, to raise the issues of the Hostile Environment barriers and stress the need for clinics to offer the vaccine without ID and to expressly advertise this.

266. Medact and Migrants Organise prepared a briefing to support the Patients Not Passports campaign that highlighted barriers and called for action to ensure access to the Covid-19 vaccine for everyone in the UK, regardless of immigration status, proof of address or ID [MPCAG/91 INQ000401187].

267. Medact and DOTWUK began to see the effectiveness of this work through the services offered by Clinical Commissioning Groups - for example the difference in the information for Lambeth clinics between the 3 June and 29 June 2021 [MPCAG/97- INQ000401193]. Campaigners used examples of effective vaccine delivery to encourage better practice [MPCAG/98 - INQ000401194].

G: MPCAG'S ENGAGEMENT WITH THE GOVERNMENT AND HEALTH SERVICES TO HIGHLIGHT THE BARRIERS TO VACCINES AND THERAPEUTICS

268. MPCAG took exhaustive steps through campaigning, lobbying, direct contact and publication of reports to alert and inform the government and healthcare bodies of the barriers preventing migrants from accessing vaccines and therapeutics. This was done before and during the pandemic.

269. It therefore cannot be said that at the material times the Government was unaware of these barriers.

270. Below is a summary of the steps taken engage directly with the Government and healthcare services:

271. On 16 March 2020 JCWI (along with other NGOs) wrote to the Home Secretary calling on her to [MPCAG/99 - INQ000142285]:

- Immediately suspend all NHS charging and NHS data-sharing with the Home Office for the purposes of immigration enforcement and mount a public campaign to communicate that action.

- Immediately suspend 'No Recourse to Public Funds' conditions to ensure that everyone can access the support they need to stay safe and self-isolate.

- Make assurances that migrants unable to attend immigration reporting appointments, court dates, or interviews whilst self-isolating would not be penalised.

- Make provision to extend or modify visas where necessary to prevent people being forced to 'overstay' and breach the terms of their visa due to self-isolating or being unable to return to a country that is not safe to travel to.

- Release everyone detained under immigration powers, to reduce the risk of Covid-19 entering the detention estate and causing avoidable harm.

- Provide specialist support for those housed in shared Asylum Accommodation to enable safe access to medical services, testing, and where necessary, re-housing for particularly vulnerable people.

272. On 20 March 2020 DOTW sent a letter to Secretary of State for Health, Minister for immigration and compliant environment, Chief Medical Officer (CMO) for England, CEO of NHS England and Chief Executive of Public Health England raising urgent concern about the lack of guidance, advice or support for vulnerable migrants living in the UK on how to respond to Covid19 and how to access NHS testing and treatment services. DOTWUK called on them to urgently produce Covid-19 advice and guidance for this patient group in an accessible form including a wide range of languages with dissemination through local communities and to immediately suspend data-sharing between NHS trusts and the Home Office.

273. On 25 March 2020 JCWI sent a briefing to the Home Affairs Select Committee [MPCAG/100 - INQ000108564]. This briefing recommended a number of urgent measures necessary for public health including, *inter alia,*, (i) to suspend the NHS charging regime, (ii) to end data sharing between the NHS and the Home Office, (iii) to pursue an information campaign to inform NHS

staff of these changes, (iv) to lift all NRPF conditions, (v) to release all immigration detainees, (vi) to ensure extension of leave and suspension of visa conditions (to prevent individuals becoming undocumented), (vii) to ensure safe access to medical services for those in asylum accommodation.

274. On 27 March 2020 Kanlungan, along with Refugee and Asylum Participatory Action Research ('RAPAR'), sent an open letter to the government calling for Leave To Remain to be granted to all undocumented migrants.

275. On 6 April 2020 DOTWUK submitted written evidence to the Home Affairs Select Committee inquiry on Home Office preparedness for Covid-19 and recommended a number of urgent measures necessary for public health including [MPCAG/79 - INQ000142182]:

    i. Translate all Covid-19 guidance for the general public into the languages most commonly spoken by those going through the asylum system and National Referral Mechanism (potential victims of trafficking) and launch a public health information campaign to reach asylum seekers and survivors of trafficking.

    ii. Suspend NHS patient charges for the period of the Covid-19 pandemic accompanied by a clear and widespread information campaign to assure the public.

    iii. End all data-sharing between NHS trusts, DHSC or NHS Digital and the Home Office for immigration decision making or enforcement, and launch an information campaign to assure the public - including all migrants and NHS staff - that patient information will no longer be shared in this way.

276. On 13 April 2020 DOTW, along with the British Medical Association, Faculty of Public Health, Royal College of Child and Paediatric Health, President Royal College of Obstetrics and Gynaecology, , Royal College of Physicians, Royal College of Emergency Medicine, Royal College of Child and Paediatric Health, Royal College of Obstetrics and Gynaecology, Royal College of Midwives and other NGOs wrote to Home Secretary and Secretary of State for Health and Social Care calling for a suspension the National Health Service (Charges to Overseas Visitors) Regulations 2015 and 2017 (i.e., the NHS charging regime) and all associated immigration checks and data sharing, which risk undermining national efforts to stop the spread of Covid-19. The Government responded to this letter (on 30 June 2020) stating that Ministers had considered the request to completely suspend the Charging Regulations but did not consider it to be proportionate. Similarly, the government confirmed that it had no plans to completely suspend the very limited data arrangement between the NHS and the Home Office at this time.

277. On 7 May 2020 DOTWUK submitted further evidence to the Home Affairs Select Committee inquiry on Home Office preparedness for Covid-19 outlining evidence that (i) NHS trusts and patients, have low levels of understanding of the complex NHS charging regulations and (ii) the NHS charging regulations cause racial discrimination within NHS services [MPCAG/101 - INQ000401092].

278. On 10 July 2020 JCWI submitted Evidence to the Women and Equalities Committee Inquiry on Covid-19 and the impact on BAME communities [MPCAG/102 - INQ000401093]. This report drew attention to evidence that the Government was suppressing evidence that its failings in the handling of the pandemic had contributed to disproportionate levels of deaths among BAME communities. The Government subsequently failed to publish evidence from NGOs on deaths caused by the immigration system. The report details the harm caused to the BAME community during the pandemic by Hostile Environment policies.

279. On 27 July 2020 DOTWUK (with Greater London Authority, Faculty of Public Health, Association of Directors of Public Health, various local authorities) wrote to the Secretary of State for Health and Social Care and Housing Communities and Local Government calling for national Covid-19 guidance in languages that reflect England's multilingual communities.

280. On 19 November 2020, Kanlungan attended a Housing and Communities roundtable meeting with GLA's Housing and Land Team to discuss their concerns.

281. On 26 November 2020 DOTWUK (with British Medical Association, Faculty of Public Health, Royal College of Psychologists and various NGOs) wrote to the Home Secretary calling for the Napier barracks to be closed as an asylum accommodation site due to the lack of access to adequate and appropriate healthcare services and the public health risks resulting from a lack of compliance with the Covid regulations [MPCAG/103 - INQ000235280].

282. On 26 November 2020 Kanlungan attended a meeting with the Mayor of London, Sadiq Khan, chaired by Deputy Mayor Dr. Debbie Weekes_Bernard to discuss their community's experiences during Covid-19.

283. In 2020 and 2021, Kanlungan attended meetings with NHS North East London, that was coordinated by Hackney CVS, to discuss communication and translation of Covid-19 guidance into community languages.

284. In January 2021, Kanlungan, along with other organisations, provided a response to the 'Call for Evidence on Ethnic Disparities and Inequalities in the UK: a joint response from academics, politicians, professionals and organisations who come from and represent the East Asian and South East Asian communities in the UK'. [12]

285. On 14 January 2021 JCWI wrote to the Scientific Advisory Group for Emergencies (SAGE), urging them to examine the ways in which Home Office policies were putting migrants' lives in danger during the pandemic [MPCAG/104 - INQ000142280]. JCWI called for: (1) a vaccination programme that was accessible to everyone; (2) the ending of NRPF and access for all migrants to the social safety net; and (3) for a suspension of detention and deportations to prioritise public health over immigration enforcement.

[12] Kanlungan *Response to the Call for Evidence on Ethnic Disparities and Inequality in the UK* January 2021 **[MPCAG/103a - INQ000474439]**

286. On 21 January 2021 JCWI wrote to the Home Secretary to raise ongoing concerns about lockdown, the vaccination and lack of government action to protect migrants, despite previous and repeated calls for action.

287. In January 2021 DOTWUK emailed DHSC NHS Cost Recovery Team raising concern that an NHS trust had issued a letter to a patient requiring them to bring paperwork to prove their entitlement to NHS services to a vaccine appointment.

288. On 17 February 2021 Medact and Migrants Organise wrote to the Secretary of State for Health and Social Care, Matt Hancock, to raise the structural barriers that the Hostile Environment created to accessing vaccines [MPCAG/105 - INQ000137486]. The letter was supported by 231 organisations whose names are listed at the end, illustrating the breadth of support and unity in the requests being made to remove Hostile Environment policies and effectively communicate this. The DHSC replied four months later, in June 2021, referencing a Public Health England circular confirming access for undocumented people and confirming that the Covid vaccine was free for all. It was stated that that NHS providers had been "advised" not to share information with the Home Office or ask for status details for those accessing Covid services [MPCAG/106 - INQ000401097].

289. On 3 February 2021 DOTWUK, with Helen Bamber Foundation, Forrest Medico-Legal Services and Freedom from Torture submitted written evidence to the Home Affairs Select Committee on Home Office preparedness for Covid-19 outlining clinical concerns relating to the use of former MOD sites as asylum accommodation following a major Covid-19 outbreak at Napier Barracks and that the continued use of barracks was undermining the efforts and sacrifices made by the British public to stop the spread of Covid-19 [MPCAG/107 - INQ000401098].

290. On 3 February 2021 DOTWUK submitted written evidence to the Home Affairs Select Committee inquiry on Home Office Preparedness for Covid-19 calling for the Home Office to (i) amend the Asylum Accommodation and Support Statement of Requirements to ensure that all residents housed or anticipated to be housed in Initial and Contingency accommodation for 19 days or longer to register with a GP and (ii) produce translated, tailored and accessible Covid-19 guidance for asylum seekers in initial accommodation, hotels and dispersal accommodation [MPCAG/108 - INQ000401099].

291. On 8 February 2021 DOTWUK emailed Public Health England raising concern that *"There really is a very pervasive fear that the NHS is working hand in hand with the Home Office to collect information to help deportations, and this is hard to counter.... Even those who shouldn't worry about accessing the NHS – like asylum seekers and refugees – worry about disclosing migration status to NHS staff. Its partially fear of being deported, and partially fear of being treated differently (experimented on, given cheaper drugs ect)".*

292. On 10 February 2021 DOTWUK emailed DHSC NHS Cost Recovery Team calling for clearer communications on the risk of data sharing with the Home Office for those accessing a Covid-19 vaccine appointment: *".... We need is clear communication on what the current situation is.*

The "no immigration checks" line is not working. It doesn't go far enough (people need reassurance that their info will be kept confidential) and its undermined by the fact that GP practices do often ask for poof of immigration status. As far as we (and everyone I speak to) is aware, there are no processes by which primary care could share data with the HO. I think what we need to be aiming for is messaging along the lines of: GPs / primary care will never share any information about you with the Home Office immigration department".

293. On 27 March 2021 Kanlungan sent a further open letter to the Government, along with StatusNow4All, calling for Indefinite Leave to Remain to be granted to all undocumented migrants.

294. On 25 June 2021 DOTWUK submitted evidence to the All-Party Parliamentary Group on Detention's inquiry into quasi detention calling for Napier barracks to be closed as accommodation for migrants on public health grounds.

H: RECOMMENDATIONS TO REMOVE BARRIERS

295. The purpose of the Covid-19 Inquiry here is to now undertake the long overdue and independent examination of the harm caused to individual migrants and to wider public health and safety by enmeshing Hostile Environment immigration policies with access to access to healthcare.

296. We consider that the Inquiry currently has before it the necessary evidence, considered alongside the Home Office and Government's response (if provided), to make the unequivocal findings and recommendations we have proposed.

297. Covid-19 served to highlight how critically important is it that immediate action be taken to remove barriers to healthcare for all, including migrants.

298. Successive governments have repeatedly been alerted to the public health harm created by NHS charging, NHS data sharing and the NRPF condition. These warnings have been ignored or overlooked for too long.

299. Importantly, calls on Government to suspend the NHS charging regime and NHS data sharing and associated immigration action have been made not only by frontline NGOs, but also by the British Medical Association, the Faculty of Public Health, the Royal College of Child and Paediatric Health, the Royal College of Physicians, the Royal College of Emergency Medicine, the Royal College of Child and Paediatric Health, the Royal College of Obstetrics and Gynaecology and Royal College of Midwives.

300. Urgent remedial action through the following recommendations is now required and within the power of the Inquiry to make:

i. Public health policy and objectives must be intentionally and unequivocally prioritised over immigration policy.

ii. 'Hostile environment' policies that devalue the lives of migrants, expose them to harm and increase the overall public health risk, must be scrapped. There should be no place for immigration enforcement efforts in healthcare. There is a need to allow all people living in the UK, regardless of immigration status, to be able to access all levels of health services without fear of immigration enforcement. This means that NHS charging, NHS data sharing and NRPF must be permanently discontinued or repealed.

iii. NHS Digital and the Department of Health and Social Care must implement a permanent firewall to ensure that patient data will never be shared with the Home Office or other bodies for the purposes of immigration enforcement. The Home Office should immediately destroy and publicly commit to not using for any purpose the information obtained from the Secretary of State for Health or from NHS Digital under the now defunct Memorandum of Agreement (2017).

iv. GP surgeries, hospitals and vaccines centres must be designated as safe spaces for all, protected from immigration raids and to ensure patient confidentiality and trust.

v. The Government must take direct action to remove all existing barriers to GP registration and access to primary health care. Until this is achieved, a self-identification mechanism must be implemented to enable clinically vulnerable migrants or those working in high-risk health and social care settings to independently request priority access to vaccinations or treatment for Covid-19.

vi. There must be a cross-government strategy for reducing health inequalities and the wider socio-economic, structural and racial barriers that drive them. Recognition of the health risks posed by Hostile Environment policies must be at the heart of future policy formulation.

vii. In future pandemics, there must be early engagement with specialist organisations to inform decision-making and policy implementation based on a clear understanding of health needs of all migrants.

viii. Financial measures to alleviate hardship arising from loss of employment or income during a pandemic must extend to all, regardless of immigration status.

ix. A properly funded, language-specific and accessible public messaging campaign must be implemented to ensure public health messaging reaches migrant communities (extending to those in detention and large site asylum accommodation), including funding provision for frontline organisations.

301. We consider that the lessons learned, and recommendations made by this Inquiry will have the power to save lives and mitigate the risk of irremediable harm suffered by particular racialised and minoritised communities during any future pandemic.

302. It is therefore crucial that the recommendations made are properly evidence-based and sufficiently robust in identifying the structure of exclusion and inequality created by NHS charging, NHS data sharing and NRPF, compounded by structural racism and socioeconomic inequalities, that were wholly responsible for preventing migrants from accessing vaccines and therapeutics to the detriment of individual and wider public health during the Covid-19 pandemic.

303. On any proper analysis, the efforts that the Government did take during the pandemic to suspend some of these barriers failed in not going far enough to address the root causes of the structural barriers.

304. Anything less than recommending NHS charging, NHS data sharing and NRPF be permanently discontinued, will fail to address the root causes of the identified barriers and inequalities, and will exacerbate the exclusion, health inequalities, vulnerability, and disenfranchisement of migrants in the UK, to the detriment of wider public health and safety.

305. We respectfully urge the Inquiry to adopt in full the findings and recommendations we have set out above.

Statement of truth

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Name: Anna Miller, DOTWUK

Personal Data

Signed: _____

Dated: _____04/10/2024_____

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Name: Mary Atkinson, JCWI

Personal Data

Signed: _____

Dated: _____04/10/2024_____

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Name: Lorie Halliday, Kanlungan

Personal Data

Signed: _____

Dated: ____04/10/2024_____

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Name: James Skinner, Medact

Personal Data

Signed: _____

Dated: _____04/10/2024_____