

Healthcare access for migrant children in England during the COVID-19 pandemic

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HEALTHCARE ACCESS—A CHILD RIGHT

Access to healthcare services without discrimination is fundamental to the right to health. The principles of equitable, accessible, affordable healthcare are also embedded within the United Nations (UN) resolution on Universal Health Coverage, hailed as ‘the single most powerful concept that public health has to offer’ by the former WHO director-general.¹ In 2016, the UN Committee on the Rights of the Child raised significant concerns regarding healthcare access inequalities between migrant and non-migrant children in the UK.² These unresolved concerns and subsequent serious child health consequences have been echoed repeatedly by leading health and migrant support experts.³ The global COVID-19 pandemic and impacts of mitigation policies have dealt multiple blows to the health and well-being of many sectors of the population, particularly those already living precarious lives. Migrant families and children are recognised as a group already burdened with health challenges and barriers to healthcare access which risk further exacerbation during and beyond the COVID-19 pandemic.³ The ongoing public health crisis presents an urgent and distinctive opportunity to permanently address the unacceptable hostile policy and practice environment that restricts equitable healthcare access, endangers child health and so poorly enables the rights of migrant children to be realised.

MIGRANTS IN THE UK

In 2017, an estimated 6208000 foreign national individuals resided in the UK, including 332604 children and young people (CYP) from the European Economic Area (EEA+) and 332000 undocumented CYP. An estimated 133000 CYP without secure immigration status were estimated to be living in

London alone.⁴ Undetected victims of international human trafficking, including family units and children, are likely to number in their thousands.⁵

In 2018, asylum seekers represented approximately 6% of immigrants (34500 people) in the UK.⁶ Five thousand six hundred and fifty-five dependent children under the age of 18 years were included in asylum applications, including 2711 under the age of 5.⁷ Between May 2018 and 2019, 2872 unaccompanied minors applied for asylum. Additionally, around 20000 refugees have been resettled through government schemes.⁸

Migrant individuals are therefore very diverse, with potentially complex, nuanced and even harrowing reasons for leaving ‘home’. For those who are fit and able to travel, perhaps entering the UK for employment, study or family reasons, reported that health is often better than their UK counterparts.⁹ For those in need of sanctuary, compounding experiences of profound human cruelty, human rights violations, chronic oppression, threat or severe strangulation of opportunity are the burden of many. Migrant children may have been subject to chronic conditions of poverty, food insecurity, heightened risk of disease, disorder, abuse, injury and trauma both before, during and after migration resulting in underlying malnutrition, prolonged stress, the impacts of active disease and the sequelae of chronic illness and its inadequate management.¹⁰

Far from being the great equaliser, the COVID-19 pandemic has starkly exposed and widened the inequalities of society further, with the poor and disempowered disproportionately affected through disease, difficulties accessing healthcare, social support weaknesses, local economic shocks and the relayed impacts of dangerously unstable global markets.^{11 12} Many migrants with complex medical histories, subsequent multifactorial



weakening of the immune system and ongoing challenging socioeconomic circumstances should be considered at high risk of COVID-19 complications.¹³

Concerningly, the emerging evidence suggests excess mortality due to COVID-19 in Black, Asian and minority ethnic (BAME) populations, with individuals of Black African, Black Caribbean and Asian ethnic groups at the highest increased risk.¹⁴ Socioeconomic factors, working environments, the legacy of racism and the hostile political environment towards migrants are likely to have critical contextual roles in understanding this data. Early evidence regarding BAME children has suggested that they are at greater risk of COVID-19 complications requiring hospitalisation.¹⁵ Migrant BAME children experience the pandemic differently to children not exposed to these additional challenges, and as a group are facing greater risks of caregiver illness, bereavement, poverty, racism and vicarious racism, lack of educational access and healthcare, all with significant consequences for their physical, mental and developmental well-being. The overarching public message that COVID-19 poses little threat to children directly risks isolating migrant and BAME children further from much needed policy consideration, needs assessment and support.

ELIGIBILITY FOR NATIONAL HEALTH SERVICE (NHS) HEALTHCARE

Free NHS healthcare access eligibility in England is tied to immigration status and lawful, settled residence. Eligibility may change rapidly in line with immigration decisions and is very complex for both migrants and professionals to navigate. All adults and children in England are entitled to register with a general practitioner and receive free primary care, regardless of immigration or other status. Accident and emergency treatment is also exempt from charge as are a number of defined conditions including COVID-19 testing and treatment and direct health consequences of torture and domestic violence. Many migrants are exempt from NHS charges in line with British nationals including refugees, asylum seekers, recognised victims of modern slavery and their children (<18 years), unaccompanied minors looked after by a local authority and immigration detainees. Non-EEA migrants in the UK under visa restrictions (ie, for work or study) must pay an annual immigration health surcharge, currently standing at £400 per adult and child (rising to £624 this October) that enables them to use the NHS in line with British nationals. In May 2020, the government responded to pressure to commit to removing the health surcharge requirement for non-EEA migrant NHS staff and care workers (many on minimum wage).¹⁶ It is not confirmed whether the exemption applies to their dependents, or if the surcharge will be dropped for other staff groups.

All individuals outside of these exemption groups, including undetected international human trafficking victims, non-EEA migrants with a visa for less

than 6 months stay and those without lawful residence (including visa overstayers) may be charged for NHS care at 150% tariff. This includes charges for maternity and paediatric care.

Immigration and residence status does not only determine healthcare access, but government legislation in 2015¹⁷ and 2017¹⁸ has embedded mechanisms of immigration enforcement within the NHS in England. Active measures include immigration status checks on patients and sharing of non-clinical patient data and outstanding debt with the Home Office,¹⁹ risking adverse immigration outcomes.

BARRIERS TO HEALTHCARE ACCESS FOR MIGRANT CHILDREN

Migrants still face many barriers in the realisation of their right to free NHS care even when eligible, and thousands of children and their caregivers subject to restrictions remain in very precarious health contexts. While England's 'hostile environment' (since renamed 'compliant environment') had been hailed as a mechanism to tackle unauthorised immigration, ripples of perceived pervasive discrimination and threat have disseminated throughout the wider migrant population. For many, the sense of being unwelcome has been painfully exacerbated by the Windrush Scandal in 2018,²⁰ widespread racist and xenophobic narrative surrounding 'Brexit' (the departure of the UK from the European Union, 2020),²¹ unsympathetic responses to refugees and current incidents of anti-Asian hate crimes, stigmatisation and bullying of children perceived to be Chinese in the wake of COVID-19.²² Murphy *et al* demonstrated that healthcare professionals have recorded recent instances of profound harm to migrant families and children, including interuterine death and delayed treatment of childhood cancer where access to necessary healthcare has been deeply feared and avoided, denied (without payment) or delayed.³

Testing and treatment of COVID-19 have been decreed free of charge and exempt from immigration status checks,²³ yet urgent and substantial concerns remain that these exemptions cannot mitigate the extensive barriers to migrants accessing healthcare and the subsequent severe mistrust in the integrity of the NHS generated by hostile policies.²⁴ Possible symptoms of COVID-19 are diverse in presentation and severity, particularly in children,²⁵ and many will be deterred from accessing the help they need risking increased community transmission, health complications, inappropriate use of home treatments and avoidable deaths.

MOVING FORWARD—ENABLING MIGRANT CHILDREN TO ACCESS HEALTHCARE

In order to enable migrant children to realise their right to health, we recommend that:

- ▶ All migrant children have the same access to healthcare as British nationals with immediate and ongoing

effect, in line with France, Italy, Norway, Portugal and Spain.²⁶ Their healthcare access must be determined by their health or developmental needs, not by immigration status.

- ▶ All migrants must have access to NHS healthcare for ALL necessary treatments and preventative healthcare without cost during the course of the COVID-19 pandemic and ongoing. Caregivers must feel safe to attend for their own, and their children's healthcare needs without fear of debt and impoverishment.
- ▶ A firewall between the NHS, justice services and immigration must be urgently established. Migrant caregivers and children must be able to seek and receive healthcare, report violence and unsafe working and living conditions without any fear of being reported to immigration services, detained or deported.
- ▶ The healthcare surcharge for non-EEA migrants requires urgent review due to the risk of impoverishment of low-paid workers and their dependents during a season of severe economic instability.
- ▶ Research into the risks of COVID-19, social determinants of health, systemic racism, hostile policies and hostile indifference towards migrant health outcomes must be ongoing and considered through a child rights framework. All barriers to healthcare access including language and physical barriers, legal, administrative and financial constraints should be removed.
- ▶ The principles of Universal Health Coverage must be clarified through the lens of international human rights law with a view to enhanced understanding of how legal avenues can be used to combat inadequacies in current healthcare access policy.²⁷

The ongoing COVID-19 public health crisis presents an urgent, distinctive opportunity to enable the full rights of migrant children to health to be realised, recognising their situation within the wider picture of the enabled rights of their parents, carers and communities.

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