

Healthcare access for children and families on the move and migrants

Lisa Murphy ¹, Jonathan Broad,¹ Bryony Hopkinshaw,¹ Sarah Boutros,² Neal Russell,³ Alison Firth,⁴ Rachael McKeown,⁴ Alison Steele⁴

To cite: Murphy L, Broad J, Hopkinshaw B, *et al.* Healthcare access for children and families on the move and migrants. *BMJ Paediatrics Open* 2020;**4**:e000588. doi:10.1136/bmjpo-2019-000588

Received 14 October 2019
Revised 26 February 2020
Accepted 6 March 2020

ABSTRACT

Background The United Kingdom (UK) National Health Service (NHS) charging regulations have increasingly restricted migrants' healthcare access, in the context of a wider national policy shift over the past few years intending to create a 'hostile environment' for migrants. With an estimated 144 000 undocumented children living in the UK and increasing public concern that these regulations are negatively impacting migrant health and well-being, as well as contravening international child rights agreements, it has become imperative to understand their implications.

Methods A mixed methods digital survey, covering attitudes towards and understanding of UK healthcare charging, and giving space for relevant case submission, was disseminated through communications channels of the Royal College of Paediatrics and Child Health (RCPCH) to their members. Quantitative data were analysed on Stata, and basic proportions were calculated for each response proportion. Qualitative data were analysed using a framework analysis approach.

Results There were 200 responses, from a range of healthcare professional backgrounds. The majority were not confident in interpreting and applying the charging regulations. One-third (34%) reported examples of the charging regulations impacting patient care, analysis of which elicited seven key themes. Our survey gathered 18 cases of migrants being deterred from accessing healthcare, 11 cases of healthcare being delayed or denied outright, and 12 cases of delay in accessing care leading to worse health outcomes, including two intrauterine deaths.

Discussion Our results describe a range of harms arising from the current NHS charging regulations contributing to delays in or denials of healthcare, due to patients' fear of charging or immigration enforcement, including potential deportation, and confusion around entitlements. This harm affects individual patients, the migrant community and the NHS – often in multiple simultaneous ways. Many patients eligible for NHS care, such as trafficking victims, are not being identified as such. We found the current charging regulations to be unworkable, and that harm could not be eliminated simply through improved awareness or implementation.

BACKGROUND

Recent National Health Service (NHS) charging regulations have increasingly restricted access to the United Kingdom (UK) National Health Service (NHS) for

What is known about the subject?

- ▶ Excluding certain migrant groups from healthcare access often results in greater health system costs, as demonstrated in several European Union studies.
- ▶ The NHS charging regulations are a deterrent to healthcare access for certain migrant groups and are a source of harm to individual patients and to public health, as reported by Maternity Action, Doctors of the World, and the British Medical Association. Most of the evidence relates to pregnant women and other adult migrant populations, and is often focused around a number of high-profile cases.
- ▶ NHS charging regulations are putting a strain on healthcare professionals at a time of already stretched services.

What this study adds?

- ▶ The NHS charging regulations are having direct and indirect impacts on migrant children and pregnant women, with evidence of a broad range of harms.
- ▶ There is a lack of understanding of current NHS charging regulations and their intended application among healthcare staff.
- ▶ The NHS charging regulations are unworkable and are having a detrimental impact on the wider health system, as well as conflicting with its staff's professional and ethical responsibilities.

migrants, particularly in England.¹ They have been introduced as one part of a suite of national policies intended to create a 'hostile environment' for undocumented migrants in the UK by embedding immigration control within and restricting access to public services.² Reasons why a migrant child might be undocumented include being born to undocumented parents, being an unrecognised survivor of trafficking, or due to financial barriers to regularise their status. In this context, and in light of the UK's commitment to uphold the "highest attainable standard of health" for all children under the United Nations Convention on the Rights of the Child (UNCRC),³ it has become imperative to understand the impact of the NHS charging



© Author(s) (or their employer(s)) 2020. Re-use permitted under CC BY-NC. No commercial re-use. See rights and permissions. Published by BMJ.

¹Medact, London, UK

²Institute of child health, University College London Institute of Child Health, London, UK

³Molecular and Clinical Sciences Research Institute, University of London St George's Molecular and Clinical Sciences Research Institute, London, UK

⁴Royal College of Paediatrics and Child Health, London, UK

Correspondence to

Dr Lisa Murphy; lisaanna.murphy@gmail.com



regulations (see online supplementary appendix 1) on migrant children and their families.

The 2014 Immigration Act,⁴ changed the definition of 'ordinarily resident' (the condition on which eligibility for free NHS care depends) and thereby further restricted access to the NHS for people with irregular immigration status.⁵ Since then, the charging regulations of 2015 and 2017¹ include: (i) charging for most secondary and community care, (ii) charging at 150% of the NHS tariff for chargeable patients, (iii) upfront charging before treatment is provided (unless urgent or immediately necessary), and (iv) debts of >£500 being reported to the Home Office, which could result in migrants facing immigration enforcement measures such as detention, deportation or the jeopardising of immigration applications. NHS trusts are delegated the responsibility to identify those deemed ineligible for free care and bill them accordingly, through 'Overseas Visitor Managers' or similar offices. Clinical staff are required by the 2017 charging regulations to determine whether a patient's care should be charged prior to treatment, or is deemed 'urgent or immediately necessary' and thus can be billed retrospectively.

Certain patient groups, such as asylum seekers, refugees, victims of trafficking recognised by the National Referral Mechanism, and children looked after by the local authority, are exempt from charging. Additionally, some infectious diseases, notifiable infections, and conditions which arise as a result of violence (domestic, sexual, torture, female genital mutilation) are also exempt.¹ Care given in emergency departments and in primary care currently remains free of charge for all. Extension of charging into these services has been proposed, however,⁶ and significant barriers have been noted for migrant families to access primary care beyond financial considerations. For example, much of the paperwork often mandated prior to registration by general practices, such as photographic identification or proof of address, is incompatible with NHS guidance, and disproportionately impacts vulnerable groups such as migrants.⁷

Undocumented migrants in the UK, estimated to number around 618 000 (including 144 000 children),⁸ are also facing increasing immigration application fees and cuts to legal aid.⁹ The majority of these individuals cannot access employment, rent, or any mainstream welfare benefits.⁸ It is therefore increasingly difficult to regularise their immigration status, thus driving families and children further into destitution.⁸ Being in such precarious situations puts migrants at further risk of exploitation, domestic violence, and modern slavery. This is especially concerning for children, as their immigration status generally depends on that of their parents. It is currently unclear whether the UK's exit from the European Union will lead to the loss of formal immigration status for a further cohort of children and, if so, how many children this would affect.

Several medical colleges, including the Royal College of Paediatrics and Child Health (RCPCH), have publicly

stated their concern about the impact of these regulations on migrant health and well-being.¹⁰ As a team of child health professionals, we therefore wished to investigate this impact in relation to the population we care for. We collaboratively conducted a survey of frontline professionals, with the RCPCH policy team, on their views and experiences of NHS charging for children and pregnant women. The survey aimed to understand healthcare professionals' knowledge of and attitudes to NHS charging regulations and to understand the impacts of the charging regulations and wider migration policy changes in practice. While the charging regulations primarily target short-term visitors to the UK and undocumented migrants, we wanted to also explore whether there are impacts on wider migrant populations, and this article covers experiences of professionals working with refugees and asylum seekers, as well as undocumented migrants.

METHODS

Survey design

A mixed methods digital survey was developed by five clinicians and further refined following review by experienced RCPCH researchers. The survey (published in full in online supplementary appendix 2) was designed for adaptability and comparison with other medical specialties and patient populations. The survey included 12 Likert scale questions and five binary yes/no questions intended to measure practitioners' attitudes towards, and understanding of, policies restricting healthcare access eligibility in migrant groups. It also included three qualitative free-text questions, investigating themes of deterrence and delay of healthcare, as well as the wider impacts of hostile policies on migrant children and pregnant women.

Recruitment and participants

The survey was open to participation to all children's health practitioners working in the UK, including paediatricians, healthcare students, midwives, nurses, other doctors, and child health specialists. A variety of recruitment methods were utilised. RCPCH members were emailed via four email bulletins: to those members on specific mailing lists for research and clinical leads, then once to the entire membership who consented to emails (14 598 emails sent in total). Recruitment messages were all within a wider email bulletin including unrelated content. It was also shared five times on a social media platform (Twitter), on which 17 000 people were followers at the time. The proportion of email recipients who are on multiple email lists, or who also engage with the college's Twitter channel, is unknown. A targeted recruitment method was also adopted in two London teaching hospitals with large paediatrics departments. In these hospitals, members of paediatrics departments also received an additional email and two researchers orally

announced the surveys in departmental meetings (to approximately 500 staff and students).

Data collection

The survey collection period was 2 months (January–February 2019) in which participants could submit their responses. Participants could submit their responses anonymously either via an online tool (SurveyMonkey) using computers or other handheld devices, or in paper format into sealed boxes left in hospital departments.

Data analysis

Quantitative data were analysed on Stata, and basic proportions were calculated for each response proportion. Non-responders were not included in the denominator, therefore the proportion presented is in relation to the number of responses per question, not overall participants. Qualitative data were analysed using a framework analysis approach.¹¹ JB and LM reviewed the data separately, devised a coding framework independently, then formed a framework by consensus, with overall themes and subcodes that had an agreed definition. This framework was then applied independently by LM and two researchers who had not developed the framework (RM and BH). The framework that was developed can be found in online supplementary appendix 3.

Patient and public involvement

No patients or members of the public were involved in the design or conduct of this research. This was not thought pertinent for our research at this time, as we were seeking to understand healthcare professionals' experiences. Additionally, as those affected by the charging regulations are often in precarious situations in the UK they can be difficult to engage and are often understandably reluctant to participate in research or publicly describe their stories.

RESULTS

Quantitative results

In total there were 220 responses to the consultation; however, 20 respondents only inputted their profession and location without responding to any other question on the survey, and so they were excluded from subsequent

analysis. This is a similar response rate to that of other surveys disseminated by the RCPCH. A range of professionals were included in the survey including midwives, nurses, allied health professionals, medical students and charity workers, with doctors being the most numerous (44.5%), comprising paediatric consultants, trainees, general practitioners, and trust grade doctors (figure 1). All four nations were represented, although 69.5% of respondents were from Greater London. This may be explained by the fact that London has the largest number of migrants compared with other UK regions.¹² As all the questions included in our survey were not compulsory there was variance in the number of questions answered by our respondents. In the results we have therefore indicated the number of individuals (denoted by 'n') who answered each question.

The majority of professionals (53%) strongly disagreed or disagreed that they were confident in the definition of urgent and immediately necessary care. For all questions, the majority of professionals strongly disagreed or disagreed that they were confident in determining which circumstances, conditions and groups patients would be charged in, either upfront or retrospectively. Those who reported feeling confident in their understanding of the regulations came from a range of healthcare backgrounds and were spread across the country, with no clear commonality between them. Respondent answers to these Likert scale questions are detailed in table 1.

Most respondents (60%) felt that the policies of charging migrants for NHS care was unfair, and the majority felt that healthcare professionals should not play a role in implementing charging (58%). The majority of respondents were not confident that they would be covered by their indemnity providers (81% not confident) or the General Medical Council (GMC) (87% not confident) in case of harm coming to a patient as a result of their interpretation or implementation of the charging regulations (see table 2).

There was a lack of awareness of the Department of Health and Social Care's 2017 review into the impact of the charging regulations among respondents, with 71% of respondents not aware it had been carried out. However, 76% reported that they felt there was a need for an independent review of these regulations.

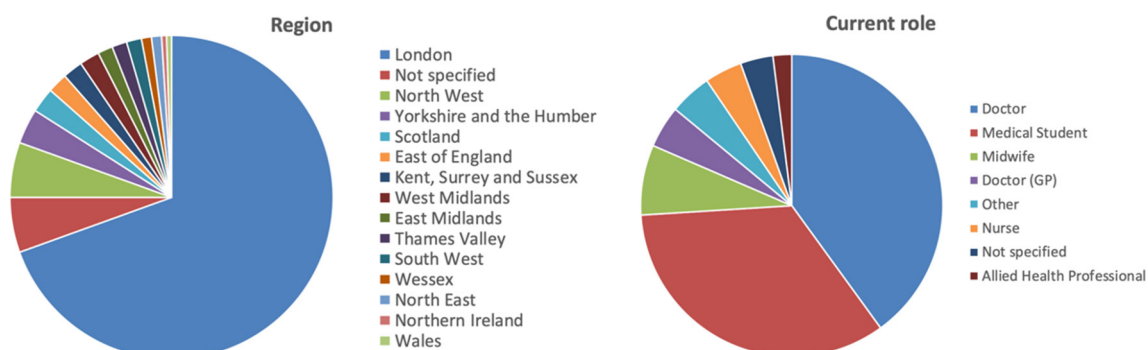


Figure 1 Survey respondents' demographics, showing their professional role and location within the United Kingdom (n=200).

Table 1 Knowledge of and confidence in the charging regulations among respondents**"I am confident in determining/my knowledge of"...**

Parameter	Strongly disagree	Disagree	Neutral	Agree	Strongly agree	Total
How to define urgent/immediately necessary	56 (29%)	45 (24%)	42 (22%)	37 (19%)	10 (5%)	190
How to advocate for patients	47 (36%)	32 (25%)	25 (19%)	16 (12%)	9 (7%)	129
When to charge retrospectively	64 (51%)	34 (27%)	15 (12%)	6 (5%)	6 (5%)	125
When to charge upfront	63 (50%)	33 (26%)	13 (10%)	10 (8%)	6 (5%)	125
Which services are exempt	73 (38%)	50 (26%)	32 (17%)	23 (12%)	12 (6%)	190
Which conditions are exempt	94 (50%)	48 (26%)	19 (10%)	21 (11%)	5 (3%)	187
Which patients are exempt	67 (52%)	33 (26%)	10 (8%)	12 (9%)	6 (5%)	128
Which patients are chargeable	61 (32%)	58 (31%)	43 (23%)	19 (10%)	9 (5%)	190

Some 12.4% of those who responded to the question of whether they had received training on this topic (n=178) said they had, although we did not assess the details of any training received. Those who responded to the question of whether they would like to receive further training (n=112), 72.3% responded positively.

Qualitative results

One-third (34%) of respondents reported that they knew of examples of how NHS charging regulations had impacted patient health and care. They were subsequently asked to describe these known cases under three themes: 'healthcare seeking', 'healthcare withheld' and 'wider impact of charging'. Review of the responses using our analysis framework elicited seven key themes (detailed definitions of which are in online supplementary appendix 4). Free-text answers were then grouped within these themes, with several responses cross-cutting several themes.

Theme 1 - Patient fear of consequences of engagement in healthcare

At least 19 cases documented patients and families afraid to come into contact with health services, avoiding attendance or disengaging from care. A recurring narrative was that of fear of receiving unaffordable bills for healthcare. At least six women were reported as having presented late in pregnancy or in labour due to fear of charging. Seven of our respondents mentioned a fear of deportation as a consequence of accessing healthcare. Healthcare facilities were seen as being complicit in information sharing with other government agencies, and as such patients were deterred from care due to fear of data sharing,

and potential deportation and criminalisation. One respondent stated that: "*Patients at my hospital frequently do not attend with their children as they have overstayed their visa and fear deportation if they come to our attention*".

Theme 2 - Deterrence from accessing healthcare

Our survey found 18 cases of migrants being deterred from accessing healthcare, including preventative measures such as screening. Respondents worried that the charging regulations were leading to racial profiling, having witnessed non-Caucasian patients being asked to 'prove' their eligibility at a higher rate. Respondents expressed concern that healthcare seeking in this group is already low, and that the charging regulations could be exacerbating this. One answer described experiencing "*Patients presenting to accident and emergency late, where migration status was one factor contributing. Profiling leading to all sorts of people being deterred, for example, both migrants and people with learning disabilities who now feel they need a passport to access care*", with several responses detailing "*pregnant women avoiding antenatal care for fear of the huge bill and their details being shared with Home Office*". Respondents also highlighted that individual cases could resonate throughout migrant communities, with one case of charging or hostility causing widespread fear of accessing healthcare.

Theme 3 - Delay in or denial of healthcare provision

Our survey gathered 11 cases of pregnant women and children having healthcare delayed or denied outright due to the current charging regulations. One case reported in our survey was of a "*2-year-old boy in UK on government resettlement scheme (with full refugee status) turned*

Table 2 Opinions on indemnity and General Medical Council (GMC) coverage in relation to patient harm resulting from charging regulations among respondents**"I am confident that (xxx) would provide me with protection if a patient under my care had their healthcare delayed/withheld as a result of the regulations"**

Scenario	Strongly disagree	Disagree	Neutral	Agree	Strongly agree	Total
Indemnity coverage	79 (62%)	24 (19%)	16 (13%)	6 (5%)	3 (2%)	128
Protection by GMC	89 (70%)	22 (17%)	7 (5%)	7 (5%)	3 (2%)	128

away from outpatient hospital appointment for review". In some cases, this was because care was not deemed 'urgent or immediately necessary', or there was disagreement between healthcare professionals on the level of care which should be provided. In others, a lack of knowledge of exemptions to charging meant that patients had their care delayed or denied. The potential impact of this was outlined by one respondent who said: "Treatments that were not immediately life-saving but that were potentially life-prolonging and disability-sustaining withheld for days or weeks while entitlement to NHS care clarified". The issue of when eligibility was assessed came up in several responses, with non-clinical staff acting as 'gatekeepers' to care. Cases reported in our survey covered a wide range of clinical scenarios, including children with cancer, congenital conditions, and individuals requiring surgery. In one reported example, a "child presented with leukaemia required intensive care treatment and to start chemotherapy. Had EU passport but resident in Africa. Hospital unwilling to start chemotherapy until deposit funds provided therefore treatment delayed".

Theme 4 - Impact of charging regulations on patient health outcomes

Our respondents detailed at least 12 cases of delay in accessing or receiving healthcare leading to potentially avoidable health complications or poor outcomes. This included two cases of intrauterine death in pregnant women who had been deterred from accessing antenatal care. Four respondents told of children presenting in a critical condition due to a delay in attendance, with one saying "I've seen children being brought to ED [emergency department] very sick/not having consulted the GP [general practitioner] before because of concerns about this. Also we often see young children which have other health or dental problems discovered incidentally as they have not sought care because of this". In many cases, the patient's length of stay was extended due to late presentation leading to increased care requirements. One case described a child "born with a severe and life-limiting condition which could have been detected antenatally if she had received antenatal care at the right time in pregnancy"; another described the case of an unwell child where the "case needed to be reviewed by a specialist centre to determine treatment options, but they refused to see her as 'not eligible for NHS care'... Case was clearly immediately necessary and she should have been seen regardless. My colleague was able to go back to specialist hospital to advocate for patient and they eventually saw her after an unnecessary delay to her care". There was also disengagement from, or non-compliance with, prescribed care reported, due to fear of charging or immigration enforcement.

Theme 5 - Current charging regulations unworkable

Many respondents described cases in which the current regulations were implemented incorrectly or in a manner which was felt to be harmful to patients and their families. A broad range of different issues relating to implementation were described, including issues determining

eligibility, failure to identify exemptions, and lack of coordination between clinical and non-clinical staff.

There were numerous cases of eligible patients being inappropriately billed or threatened with billing, with one respondent saying "We know that twice as many people that were technically under these regulations got sent bills than were actually required to pay them". It was highlighted that not only is knowledge of exemptions to charging low, they can be hard to identify. One case told of a woman who "had been trafficked into the UK, and her 'partner' had all her documents which she could not access, suggesting she may have been in modern-day slavery. She was also being domestically abused. All these criteria could have identified her as exempt from charging, but they were not identified until after the baby was born". Respondents reported frustration that administrative staff would act independently of clinicians, for example, visiting patients on wards to assess eligibility or collect payment for care. In two cases they brought bills to families on clinical wards, causing confusion and distress about whether a child was able to continue receiving care.

Theme 6 - Impact of charging regulations on the NHS

Many respondents felt that the charging regulations were having an undue burden on our health system, and in particular on the staff working within it. Respondents stated that not only did it go against their professional duties as stated by their regulatory bodies, but against their own values and the principles of the NHS. This sentiment was encapsulated by one respondent who said "I feel exorbitant charging for immigrant children and the undue delay getting things done [procuring equipment, getting consultations] for such children would create a bad reputation. As a doctor I feel stressed and immoral handling this". Clinicians told of going beyond their usual duties to help patients navigate the healthcare system and advocate on their behalf against inappropriate charging. They also detailed cases where the charging regulations led to an increased burden on NHS finances and resources, noting that it was "costly to the NHS as people often need emergency treatment and hospital treatment for a condition that was treatable earlier on".

Theme 7 - Context of the wider 'hostile environment' influencing health

Respondents to our survey gave several examples of the 'hostile environment' impacting on families, including exacerbating socioeconomic inequalities and preventing access to a range of services. This ranged from affecting their access to education, to resulting in insecure access to food and shelter. In one reported instance, a "Child with life-limiting diagnosis... parents left them because they knew that unaccompanied children would get healthcare". Respondents also highlighted a lack of appreciation of health needs by immigration services, detailing that children could be placed in unsuitable accommodation or far away from the clinical team caring for them.

DISCUSSION

The results of this survey describe a range of harms, arising from various aspects of current NHS charging regulations contributing to delays in or denials of health-care. The 'Three Delays' model proposes that delays in timely care can be explained by: (1) delays in decision to seek care, (2) delays in accessing a health facility and (3) delays in receiving appropriate care at the facility.¹³ This model was originally proposed to explain contributors to maternal mortality in low- and middle-income countries, but has been adapted to describe delays in other types of care.^{14 15} Our survey results demonstrate the model's applicability to children and pregnant women being impacted by the 'hostile environment' in the UK. Fear – particularly of charging and of deportation – and confusion around entitlements, are leading to delays in seeking care (themes 1 and 2). Delays in reaching a health facility may be occurring due to destitution and unsuitable housing locations (theme 7). Once patients reach hospital, delays are occurring due to confusion around eligibility or immigration status, or due to denial of care until payment is received (themes 3 and 5). As described in other settings, the three delays can each cause harm in isolation, but even more so when occurring in combination.¹⁶ That the 'hostile environment' can impact patients in multiple simultaneous ways could explain the extent of the harm described even within this relatively small survey. This is particularly concerning given the long-term health consequences of such adverse experiences and exposure to high stress in childhood.¹⁷ Importantly, our survey only reflects cases where there was an eventual, although often delayed, attendance at a health-care facility and does not capture harmful outcomes of migrants never accessing health services at all.

In addition to demonstrating harm, our survey results suggest that the NHS charging regulations are poorly understood and poorly implemented. Our quantitative data demonstrated that clinicians' knowledge is low regarding exemptions that are meant to protect the most vulnerable. Qualitative responses suggest that many patients who would in reality be eligible for free care are not being identified as such, and are still having their access delayed or denied. Our survey highlighted several cases of trafficked victims being deterred and/or denied care, demonstrating how difficult it is in practice to implement the exemptions to charging, which exist to provide care for the most vulnerable and protect population health. Indeed, to identify those vulnerabilities, a good rapport needs to be built between patient and clinician. This is made almost impossible in the context of fear that surrounds these regulations.

Despite overall understanding of charging regulations being low, several respondents highlighted their personal experience of acting as advocates for patients, for example in identifying exemptions, or by arguing that care is 'urgent or immediately necessary' (which allows billing to be retrospective). Yet 80% of our respondents told us they felt disempowered to advocate for their

patients on charging issues due to lack of confidence, meaning this can not be consistently relied upon as a means to mitigate the harmful impacts of charging. This reliance on clinical resource for non-clinical activity may impact other areas of service delivery or put increased demands on an already overstretched healthcare workforce. Lack of understanding among non-clinical staff on healthcare access can result in patients not ever reaching clinicians, while disagreements within clinical teams may further detriment advocacy.

Our results do not support the argument that harm could be eliminated simply through improved staff awareness or 'better' implementation of regulations. Many patients were described as deterred from making contact with healthcare services, meaning that harm has already occurred before there is opportunity for advocacy. Within the cases described, harms occurring before healthcare was sought included late presentation requiring intensive care management, and two intrauterine deaths. There were several descriptions in the survey of children presenting late in their illnesses directly to the emergency department, even though accessing primary care earlier in their illness would not have been chargeable. This accords with the work done by the Equality and Human Rights Commission which suggests that it is not just specific restrictions, such as upfront charging, which act as a barrier to healthcare access, but the wider policies of the 'hostile environment'.^{18 19}

Another aspect of the unworkability of the charging regulations is the ethical dilemma in which it places clinicians. Most respondents felt that the charging regulations are unfair, and in free-text responses many commented that they felt charging conflicted with their own beliefs or the perceived values of the NHS. We did have one respondent detail a case where a person in the UK on holiday was charged for healthcare retrospectively, with the clinician believing this use of the charging regulations to have been appropriate. This was an outlier as the only reported case with a neutral or positive outcome, and so it did not fit into any of the wider qualitative themes.

The ethical issues are particularly stark when considering charging children and young people specifically. It would be likely to be considered a significant safeguarding issue if through the actions of a parent or carer, a child were prevented from accessing treatment that is in their best interests.²⁰ Yet our survey documents multiple cases of children having such treatments delayed or denied due to charging. One respondent highlighted the impossible situation for a family whose child was being treated in intensive care: "*If the family had refused treatment we would have continued anyway in the best interest of the child even if it meant going to court. So in a way we were asking them to pay for something that was out of their control... It was obviously a lot more than she was expecting or could afford, as [the mother] was distraught*". Moreover, the routine sharing of data with the UK Home Office represents a breach of patient confidentiality and, while these regulations are

being implemented, clinicians cannot guarantee confidentiality for their patients.

The most significant limitation of this survey is the lack of the patients' voices. Unfortunately, as those affected are mostly in precarious situations in the UK, they are often scared and reluctant to participate in research or publicly describe their stories. Clinicians may have been more likely to respond if they had seen cases of charging in their practice or have pre-existing opinions on the topic, and this may have led to an overestimation in the percentage of clinicians who have seen charging, or consequent harm, in their practice. In the freetext answers, respondents were instructed to keep cases vague to ensure patient confidentiality would not be breached, meaning that the full extent of the impact on those patients could not always be fully described. We also cannot exclude the possibility that where descriptions were very brief, two different clinicians may have been referring to the same patient case, although the researchers reviewing the data found that the descriptions of the cases largely did not suggest overlap.

The UK differs from comparable European countries, including France, Spain, Sweden and Italy, as being more restrictive in healthcare access for undocumented migrant children, with several European countries providing equal health rights to all children regardless of migration status.²¹ An exemption from charging for all children and pregnant women would bring the UK into line with neighbouring countries and reduce the significant safeguarding implications of the current policy. However, the evidence presented here suggests that reversing the charging regulations for children and pregnant women alone will not be sufficient to stop their impact on children. Even if children were exempt from NHS charging, these regulations and the presence of 'hostile environment' policies may still stop families from bringing children for healthcare. Furthermore, even if the children themselves can receive free healthcare, charging of their family members can lead to catastrophic health expenditure or avoidable disability which may cause or exacerbate destitution.²²

Our results are convergent with previous research carried out by the Equality and Human Rights Commission, which looked at the existing evidence on access to healthcare for migrants in the UK.^{20 21} The evidence in their reports is mostly drawn from focus group work with migrants, and from the reports of third-sector organisations. There is a large overlap in key themes, particularly with regard to fear, staff misinterpretation of regulations acting as a barrier, and the outcome of late presentation. A notable key theme present in other research but not prominent in our results was that of language barriers being a significant obstacle to accessing healthcare. As our survey was based on healthcare staff report rather than direct patient experience, staff may be under-recognising the barrier this creates to patients.

In addition to the convergent themes, our results add additional themes not reported in earlier work. This

includes healthcare staff themselves finding the regulations distressing and against their own values. They also highlight specific safeguarding and ethical issues arising from restricting healthcare to children. As our data come from clinicians and are largely drawn from secondary-care experiences, the harms may be more extensive.

Our results appear to contradict the December 2018 statement from the UK Department of Health and Social Care that their internal evidence collection of the impact of NHS charging regulations, which has been kept confidential, did not find any evidence of harm.²³ The awareness of this review among our respondents was low (29%), suggesting there may have been a limitation in its reach to frontline clinicians.

CONCLUSIONS AND RECOMMENDATIONS

Healthcare professionals are increasingly being asked to fulfil roles they are not mandated or trained for, and to potentially compromise their own values and beliefs. They have told us that they are seeing harm to the NHS, and to patients – many of whom are particularly vulnerable – as a result of policies introduced to create a 'hostile environment' for migrants. Our survey results also highlight a breach of the UK's commitment to the UNCRC, as we have recorded clear examples of violations to Article 24 on children's right to good health and healthcare access.

We therefore recommend:

Revoking current NHS charging regulations

We believe there is sufficient evidence of harm to health and well-being for the current NHS charging regulations to be revoked, thereby restoring the UK's commitment to universal health coverage. The current government should urgently suspend the charging regulations and commission a transparent independent review of their impact, using any harms that have been identified as a basis for a policy environment that upholds migrants' health and human rights.

Adding to the evidence base

Collecting further evidence of the impacts of the current NHS charging regulations will likely strengthen this call for action. A fully independent review of the charging regulations should be commissioned, to robustly assess their impact on patients and professionals. We also encourage the Department of Health and Social Care to anonymously publish the data from their previous review of the impact of NHS charging regulations for comparison and validation against our dataset.

We recommend other health professionals carry out similar surveys and a case collection process within their communities of practice, and that other Medical Royal Colleges follow the example of the RCPCH in supporting them to do so. The RCPCH will continue to host an online evidence submission for cases where the charging

regulations have impacted patient care or outcomes and encourage health professionals to contribute.²⁴

Correction notice This article has been corrected since it was first published. Provenance and peer review statement has been corrected.

Contributors LM, JB, BH, SB and NR developed the initial survey, which was reviewed by AF, AS and RM. AF and RM managed dissemination via Royal College of Paediatrics and Child Health (RCPCH) online channels. LM and JB did the initial analysis and developed the framework for analysis. LM, BH and RM coded the data gathered against the framework. LM and SB performed the further analysis and write up for the qualitative results section. JB and NR performed statistical analysis and made the included figures and tables. SB led on writing the introduction, BH led on writing the discussion, while LM and AS performed full paper editing. AF performed further review with support from RM prior to finalising the paper for submission. LM arranged the materials for submission and liaised with *BMJ Paediatrics Open* editorial staff. LM is responsible for the overall content as guarantor. This research has been carried out, analysed and authored by five child health professionals and two members of staff of the RCPCH.

Funding The authors have not declared a specific grant for this research from any funding agency in the public, commercial or not-for-profit sectors.

Competing interests None declared.

Patient and public involvement Patients and/or the public were not involved in the design, or conduct, or reporting, or dissemination plans of this research.

Patient consent for publication Not required.

Ethics approval Consultation of the Health Research Authority and Medical Research Council ethical approval decision tool found that NHS Research Ethics Service approval was not required for this research in any of the four nations of the United Kingdom.

Provenance and peer review Not commissioned; externally peer-reviewed.

Data availability statement Data are available upon reasonable request. The corresponding author is happy to release data in an anonymised fashion to any researcher, organisation or similar who wishes to review it.

Open access This is an open access article distributed in accordance with the Creative Commons Attribution Non Commercial (CC BY-NC 4.0) license, which permits others to distribute, remix, adapt, build upon this work non-commercially, and license their derivative works on different terms, provided the original work is properly cited, appropriate credit is given, any changes made indicated, and the use is non-commercial. See: <http://creativecommons.org/licenses/by-nc/4.0/>.

ORCID ID

Lisa Murphy <http://orcid.org/0000-0002-0594-9501>

REFERENCES

- 1 Department of Health and Social Care, . *Directorate of Acute Care & Workforce/Provider Efficiency & Productivity/Cost Recovery Programme/13790. Guidance on implementing the overseas visitor charging regulations*, 2018.
- 2 Taylor R. *Impact of 'Hostile Environment' Policy Debate on 14 June 2018, House of Lords Library Briefing*, 2018.
- 3 United Nations General Assembly. *Convention on the rights of the child*. . United Nations, Treaty Series, 1989: 1577. 3.
- 4 United Kingdom Parliament, House of Commons. *Immigration Act 2014*, 2014.
- 5 Lock DQ. *Overseas visitors, asylum seekers and others: who is entitled to access NHS services free of charges and who is required to pay charges for NHS services?* 2017.
- 6 Department of Health and Social Care. *Making a fair contribution: government response to the consultation on the extension of charging overseas visitors and migrants using the NHS in England*, 2017.
- 7 Doctors of the World. *Registration refused: a study on access to GP registration in England*, 2017.
- 8 Dexter Z, Capron L, Gregg L. *Making life impossible - how the needs of destitute migrant children are going unmet*. The Children's Society, 2016.
- 9 Sigona N, Hughes V. *No way out, no way in. irregular migrant children and families in the UK*. Research Report: ESRC Centre on Migration, Policy and Society, University of Oxford, 2012.
- 10 Academy of Medical Royal Colleges. *NHS charges for overseas visitor regulations: a statement from the Academy of Medical Royal Colleges*, 2019.
- 11 Ritchie J, Spencer L. Qualitative data analysis for applied policy research. In: Bryman A, Burgess RG, eds. *Analyzing qualitative data*. London: Taylor & Francis, 1994: 173–94.
- 12 Vargas-Silva C, Rienzo C. *Migrants in the UK: an overview*. Briefing Paper: Migration Observatory, University of Oxford, 2019.
- 13 Thaddeus S, Maine D. Too far to walk: maternal mortality in context. *Soc Sci Med* 1994;38:1091–110.
- 14 Calvello EJ, Skog AP, Tenner AG, et al. Applying the lessons of maternal mortality reduction to global emergency health. *Bull World Health Organ* 2015;93:417–23.
- 15 Wilmot E, Yotebieng M, Norris A, et al. Missed opportunities in neonatal deaths in Rwanda: applying the three delays model in a cross-sectional analysis of neonatal death. *Matern Child Health J* 2017;21:1121–9.
- 16 Combs Thorsen V, Sundby J, Malata A. Piecing together the maternal death puzzle through narratives: the three delays model revisited. *PLoS One* 2012;7:e52090.
- 17 Felitti VJ, Anda RF, Nordenberg D, Koss MP, Marks JS, et al. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) study. *Am J Prev Med* 1998;14:245–58.
- 18 Nellums DLBet al. *The lived experiences of access to healthcare for people seeking and refused asylum*. 122. Research Report: Equality and Human Rights Commission, 2018.
- 19 Nellums DLBet al. *Access to healthcare for people seeking and refused asylum in Great Britain*. 121. Research Report: Equality and Human Rights Commission, 2018.
- 20 General Medical Council. *Principles for protecting children and young people, Paragraph 1*, 2018.
- 21 Monde Mdu. *Access to healthcare in 16 European countries: legal report*, 2017.
- 22 Meessen B, Zhenzhong Z, Damme WV, et al. Editorial: iatrogenic poverty. *Trop Med Int Health* 2003;8:581–4.
- 23 Department of Health and Social Care. *Review of amendments made to the NHS overseas visitor charging regulations in 2017: written statement in the United Kingdom Parliament, HCWS1174*, 2019.
- 24 Royal College of Paediatrics and Child Health. Evidence collection portal for NHS charging regulations. Available: www.rcpch.ac.uk/nhs-charging-regulations [Accessed Jan 2020].