**“Drowning in bureaucracy”: The unintended consequences of NHS charging policies for the provision of care to migrant populations**

Over the past decade, the NHS has come under increasing scrutiny, with critics claiming the UK’s healthcare system is “drowning in bureaucracy” due to the introduction of multiple contradictory social policies (Torjesen, 2015, p. 1). This is particularly apparent following the implementation of the *2014* and *2016 Immigration Acts*. In an attempt to disincentivise immigration, access to a wealth of social services has been restricted for non-citizens, marking the UK’s shift towards a deliberately hostile environment (Farrington et al., 2016; Kirkup & Winnett, 2012; Weller et al*.*, 2019). More specifically, Theresa May, the then Home Secretary, positioned the rights of migrants as inferior to the rights of others, choosing to limit access to healthcare for those not ‘ordinarily resident’ within the state (Liberty, 2019). Subsequently, these individuals are charged at a rate of 150% for the cost of all non-primary healthcare, and this bill must be paid *before* they may access NHS support. Although these legal barriers to the accessibility of care pose obvious issues for the wellbeing of migrant populations (Doctors of the World, 2020; Feldman et al., 2019; Russell et al*.*, 2019; Shahvisi, 2019; Walker & Farrington, 2021), further obstacles arise in the inconsistent and often unsuccessful implementation of these policies, exacerbating the impact of hostile environment policies within the migrant population and beyond.

To establish a patient’s charging status, healthcare providers must ask questions regarding the length and nature of their residency. If an individual is found to not be ordinarily resident within the UK, their eligibility for NHS charges will be reported to an Overseas Visitor Manager (OVM), who will pursue them for payment. Despite the attempt to separate the role of caregiver and debt collector, the pursuit of chargeable patients by OVMs is only triggered by the information gathered through the healthcare providers’ initial screening. As such, current policies unintentionally place the onus on NHS staff to carry out bordering practices for which they are neither qualified nor capable of undertaking, leading many to feel as though they have been “turned into border guards” (Goodfellow, 2019, p. 2). This conflict in the responsibilities of NHS clinicians and the impact it has on the wellbeing of migrants and the institution itself lies at the heart of this argument.

Through an appeal to existing literature, this article argues that NHS charging policies are based on an inadequate conceptualisation of migrant health and the practices affecting it. The traditionally positivistic construction of healthcare charging policies has led to various failures within its implementation, which are evidenced by the emergence of ethical and practical layers of bureaucracy within the NHS. More specifically, it is argued that positivism is not *sufficient* for the creation of policy concerning a complex social issue, such as this. With the failures of positivism in mind, it is argued that policymakers must adopt a more collaborative, reflexive, and interdisciplinary approach when creating policies concerning migrant health and care. As such, an appeal to post-normal science is made (Laugharne & Laugharne, 2002). Although this paradigm shift is inherently theoretical, the consequences of it are not. Constructing NHS charging policies from a post-normal scientific perspective would have allowed for the unintended consequences of their implementation to have been foreseen. Accordingly, adjustments could have been made to its original conceptualisation which would have avoided the layers of bureaucracy currently facing NHS staff and patients. Not only would this improve rates of correct exemption identification, enhancing migrant health and wellbeing, but it would also make NHS practices more efficient, benefiting both the institution and its workers.

**Background**

***Positivism: An insufficient paradigm***

Historically, knowledge concerning medicine, health, and healthcare has been constructed within a positivist paradigm. Positivism asserts that entities exist independently of being perceived, meaning there is one, tangible and *objective* reality which we can only know through observation. By virtue of its success in the clinical field, positivism has traditionally been viewed as the dominant philosophical paradigm within research (Parke et al., 2020). As such, the majority of knowledge construction concerning *migrant* health has conformed to this positivist paradigm, meaning the nuances and complexities of migration are often overlooked or collapsed *into* the medical aspect of the research (Collins, 2010). This short-sightedness in the construction of migrant health and state policies concerning it constitutes the root cause of the unintended consequences discussed below (Maxwell, 2011). In other words, although traditional science is still *necessary* in the context of policy-making and migrant health more specifically, it is no longer sufficient.

***Post-normal science: The solution***

Funtowicz (2021) describes post-normal science (PNS) as a decision-making tool, constructed in response to the inadequacies of positivism. The primary function of PNS is to tackle policy issues in which there is a high level of uncertainty and time pressure, yet the stakes are high and have the potential to affect multiple parties (Gallopin et al., 2001, p. 222; Turnpenny et al., 2011, p. 291). This paradigm adopts a broad approach to social problems, also known as *wicked problems*, that are otherwise too complex to be sufficiently distilled via positivism alone (Funtowicz & Ravetz, 2003). Within PNS, all ontologies are viewed as equally valuable, constituting far more knowledge when taken holistically, than when taken individually. This is evident not only through PNS’ use of interdisciplinarity, but also its reliance on the collaboration of multiple peer communities. Proponents of this paradigm argue that this holistic process of knowledge construction, alongside the contribution of stakeholders, is essential for policy creation, to generate a response which matches the complexity and diversity of the issue itself (Marshall & Picou, 2008). Importantly, this shift towards PNS is not a rejection of previous research with alternative philosophical perspectives. On the contrary, this paradigm accepts all forms of research and knowledge concerning the issue of healthcare policy, viewing each as contributing something unique and otherwise unattainable (Luks, 1999; van Kerkhoff, 2010). Additionally, PNS does not claim to *solve* complex social problems, as it acknowledges the fluidity of these issues and rejects the positivist assumption that there is a *right* solution. However, its multifaceted and collaborative approach can push towards a more informed understanding and, therefore, more representative construction of the issue (Petts & Brooks, 2006; Powell, 2020). Specifically, if PNS were employed in the imagining or re-imagining of hostile environment policies, the expertise and experiences of various peer communities would have been drawn on, particularly healthcare providers. This reflexive and inclusive approach would have foreseen (and thus avoided) the unintended consequences of current hostile environment policies (Bochel & Bochel, 2017).

**Ethical bureaucracies**

In the UK, medical professionals are duty-bound to uphold various ethical standards, as formalised by the *General Medical Council* (2013). These principles are also stated in the *Universal Declaration of Human Rights* (Art. 2) and the UN’s *Sustainable Development Goals* (Goal 3.8), highlighting their universally recognised importance to individual and public health outcomes. However, hostile environment policies indirectly force healthcare providers to compromise two defining NHS principles: prioritising the patient and avoiding discrimination. As such, care providers are caught between a professional mandate to protect the wellbeing of the individual and a national policy that requires them to deny access to potentially life-saving support. This is illustrated by Reynolds and Mitchell (2019) in their case study of Albert Thompson, a Windrush migrant who resided in the UK legally for 45 years. In 2017, Albert was diagnosed with prostate cancer and was about to begin radiotherapy, to which he was entitled as a British citizen. However, the Home Office’s destruction of the Windrush landing cards led Albert to suddenly be categorised as an *undocumented* migrant. As a result, he was billed £54,000 for his upcoming treatment which he was unable to afford; he was subsequently denied access to this care. Although this example explicitly discusses the impact of charging on migrant communities, it also implicitly comments on barriers to the *provision* of care. Against their moral and professional obligations, healthcare workers were forced to deny treatment, despite knowing this may be fatal for the patient. Synthesising this case study with two professional dilemmas identified by Furman et al*.* (2007) highlights the ethical layer of bureaucracy resulting from hostile environment policies.

***Prioritising patient care***

Furman et al. (2007) asked social care students to report how they would hypothetically respond to vulnerable persons who were *morally* entitled to social services, although not legally entitled to them due to strict anti-immigration policies. The central discovery was that even when national policy pushed care workers to value migrant status over health needs, two-thirds of the respondents valued human life over following the law, with one explicitly stating, “because it is lawful does not make it right” (p. 142). Some participants even confessed to adopting illicit strategies such as a “Don’t Ask, Don’t Tell” method, as they were willing to “risk the fine or jail time” to allow vulnerable persons to access care (p. 143). This is a clear indication of the extent to which healthcare providers will go to fulfil their professional and moral obligations. However, the legal consequences of following these duties do constitute a concern for others, who stated that they would have to obey the national laws, due to fears of losing their jobs (e.g. “I have a family to think about”, p. 144) or their organisations being closed down (e.g. “[We could] not help other women and children”, p. 142).

Forcing clinicians to uphold immigration restrictions within appointments clearly damages the therapeutic relationship that is essential to the wellbeing of the patient. Moreover, even where migrants are entitled to free healthcare, for example if accessing emergency services, these individuals are deterred from seeking support, due to fears of charging. This is shown to negatively impact the individual, the public, the institution, and even the economy (de Jong et al*.,* 2017; Jones et al., 2019; Mipatrini et al*.*, 2017). As previously mentioned, stakeholders play an integral part in the construction of knowledge through PNS. With this in mind, had PNS been used to create this hostile environment policy, peer communities would have been consulted throughout the process, meaning the experiences and concerns of healthcare providers would have been considered. As such, this layer of ethical bureaucracy would have been identified and amendments could have been made, benefiting both patients and clinicians.

***Avoiding discrimination***

There is also a concern among care providers that the denial of healthcare for those not ordinarily resident constitutes discrimination, thus violating the *2010 Equality Act*. Reynolds and Mitchell (2019) discuss this with reference to the concept of justice in their critique of current policies. Justice is necessarily dependent on the frame used to define a population and as outlined by Beauchamp and Childress (1979), healthcare is inherently borderless, treating all individuals as equals. This fundamentally contradicts the sovereign state’s view of justice, which presents the frame as only including ordinary residents. The incompatibility at this purely theoretical level is evident. However, it extends beyond this, again affecting the duties of healthcare workers and subsequently undermining the wellbeing of migrant communities. One of Furman et al*.*’s (2007) respondents writes that their job is not “to identify the legality of people”, while another states they would always assume the patient is “a legal citizen and provide all services available” (p. 142). Evidently, healthcare providers fear that such policies may necessitate racial profiling and compromise the health outcomes of minority individuals, in spite of their residency status (Cutler, 2018; Greenfield, 2019; Maternity Action, 2019). These policies are also at risk of alienating the many migrants who are integral to the NHS, by implicitly stating that some individuals are less entitled to support, simply because of their race (Hiam et al., 2018). The array of stakeholders impacted by hostile environment policies, yet not consulted in their inception, exposes the insufficient nature of a purely positivistic approach to policies concerning migrant health. This, again, necessitates the shift towards PNS within the policy-making process. Facilitating collaboration between policymakers and stakeholders would have allowed the impact of charging practices to be considered from all angles, particularly whether these policies were coherent with NHS principles, clinical obligations, and moral duties. Accordingly, these ethical layers of bureaucracy arising from a short-sighted construction of the complex social issue, could and would have been avoided.

**Practical bureaucracies**

In addition to these ethical layers of bureaucracy, NHS charging policies are complex and convoluted, with official guidance now reaching over 130 pages (Mahase, 2021). As a result, many care providers do not have a sufficient understanding of the conditions for charging, leading to errors in practice and a lack of consistency across NHS Trusts. This constitutes a practical barrier to the provision of care to vulnerable persons. Such bureaucracy may even leave room for prejudicial interpretation, as confusion translates to a lack of regulatory oversight (Westwood et al., 2016). This effectively permits the imposition of one’s own political view in the restriction of healthcare. Any policy which is too convoluted to be understood, not supported by sufficient training resources, and necessitates individual interpretation requires restructuring. Again, the impact on migrant communities is obvious, with many scholars reporting the increasing failure to correctly identify charging exemptions among vulnerable persons (Feldman, 2021; Nellums et al., 2018, 2021; Pellegrino et al., 2021; Smith & Levoy, 2016). However, it is apparent that there are further reaching unintended consequences of this hostile environment practice. The complexity of charging policies exposes a knowledge deficit among healthcare providers, thus undermining the integrity and legitimacy of the institution.

***Lack of knowledge***

The *General Medical Council*’s (2013, p. 6) guide to good practice explains that healthcare providers must be “competent in all aspects of [their] work”, which includes “the law, [*General Medical Council*] guidance, and other regulations relevant to [their] work”. Despite this, the British Medical Association (2019) found that 18% of workers surveyed across the UK were completely unaware that individuals could be charged for NHS care. Even among those who were aware of these practices, there is widespread confusion. Jones et al. (2019) report that 76% of respondents incorrectly categorised “immediately necessary” care as always exempt from charging. Similarly, 40% of participants in Ipsos MORI’s (2017) study believed that *all* care was chargeable for non-exempt persons. There is also uncertainty surrounding *who* may be chargeable, which disproportionately impacts migrant populations. As Jones et al. (2019) highlight, many healthcare providers are unable to differentiate between migrant groups (e.g., refugees, asylum seekers and undocumented migrants), despite these individuals having different care entitlements. This has devastating consequences for those who are not ordinarily resident within the state, as even where they are legally entitled to care due to an exemption, their accessibility can still be curtailed due to the convoluted nature of these policies.

Jones et al. (2019) also report that less than half of all British Medical Association members felt confident in their knowledge of charging practices, with 72% reporting “some” or “significant” training needs in this area. Similarly, Feldman et al. (2019) reported that care providers do not receive explicit training on charging practices, beyond an optional online learning activity. This lack of training not only contributes to the knowledge deficit among care providers, but also enhances the workload of NHS staff who are tasked with deciphering charging exemptions without sufficient resources or knowledge. This has led 35% of NHS care providers to report an increase in workload since the introduction of charging policies, as well as 70% recognising an overall negative effect on the provision of care by the institution (British Medical Association, 2019). Disseminating incorrect and inconsistent information prevents patients from accessing support and undermines the ability to provide care in an effective and timely manner. The use of PNS in the construction of charging policies would have recognised the practical barriers that would arise for healthcare providers through its collaborative approach, therefore, the role of implementing these policies would have been better delegated to others. As such, healthcare workers would not be burdened with either the administrative or moral responsibility of establishing charging status, as these obligations would fall on individuals who have been trained to carry out these practices and face no moral dilemma in implementing them, namely, OVMs.

**Conclusion**

The concept of “unintended consequences” has been used throughout this analysis to describe the layers of bureaucracy resulting from NHS charging policies, which compromise the ethical, lawful, and effective provision of NHS care. This concept was initially formulated by Merton (1936), who examined *why* policy outcomes differ from those initially predicted, citing a range of factors including a lack of knowledge of contextual causation and placing too much emphasis on short-term consequences. However, the reason most pertinent to this argument for the use of PNS in policymaking processes is that originators of social policy may have been influenced by certain dominant discourses of the time. As a result, the policy reflects *narrow* concerns and constructions of social problems, that necessarily conflict with a *wider* set of societal values and individual experiences. Accordingly, the emergent bureaucratic processes identified throughout this essay are *unintentional*, but not necessarily *unpredictable*.

This essay has discussed the impact of NHS charging policies for the effective, lawful, and ethical provision of care. The development of ethical and practical layers of bureaucracy within the institution was discussed as an unintended consequence of this policy, arising from the insufficient nature of positivism. Two areas of ethical bureaucracy were identified, predominantly arising from a conflict between professional duties and national policies. It is evident that the obligation to charge certain individuals for healthcare violates the NHS principles of prioritising the patient and avoiding discrimination in the provision of care. This has a detrimental impact on migrants within the UK, who are denied access to necessary support and generally deterred from seeking care, even where they may be entitled to it. Furthermore, where such policies appear to motivate discrimination in the NHS, this alienates not only the migrant workers who are so valued within the institution, but also ethnic minorities within the broader public, who are unfairly profiled or even incorrectly charged, by virtue of their race. Similarly, a practical layer of bureaucracy was identified, with charging policies being too complex to implement, particularly where healthcare workers receive no training on how to enact them. This greatly impacts the migrant population as some individuals are being incorrectly charged for care they may be freely entitled to. However, it also compromises the wellbeing of healthcare staff and the efficiency of NHS processes. Considering these unintended consequences, this essay finds that the use of PNS in the initial formulation of NHS charging policies would have led to the anticipation of the layers of bureaucracy discussed in this essay, through an appeal to holism, interdisciplinarity and collaboration. In light of this, it is argued that PNS should be utilised in the creation of policy concerning migrant health, to avoid the collateral damage that arises from a unidimensional approach, such as positivism.

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