# Sustaining services, ensuring fairness

**A consultation on migrant access and their financial contribution to NHS provision in England**

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# Response template

## Overarching principles

| **Question 1: Are there any other principles you think we should take into consideration?** |
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| **Response:**<br><br>Alma Mata welcomes the inclusion of the first principle *"**A system that ensures access for all in need** – everybody needs access to immediately necessary treatment irrespective of their means or status. In particular, no person should be denied timely treatment necessary to prevent risk to their life or permanent health."* As healthcare professionals, we strongly believe that immigration status should never be a barrier to good health. We would also like the inclusion of "urgent treatment" within this principle.<br><br>We also agree with the principle that there should *be "**A system that is workable and efficient** – any new rules and systems must enable the NHS to recover charges and to use* |

*its public funds appropriately. In doing so it must not compromise the efficient, cost-effective and safe delivery of quality healthcare or place undue burdens on staff. The role of NHS staff should not extend to immigration control, and clinicians should not be diverted from treating patients."* However, we do believe that the proposals outlined are in direct conflict with this principle. It is important, when considering efficiency, to be explicit that the proposed system should not be independently projected to cost the taxpayer more than the current system. This cost analysis should take into account the cost of administering the new system, the cost of diverting patients from primary care to A&E, the cost of delayed diagnosis and treatment, and the cost to the economy of fewer migrants living, working, and spending money in the UK. We strongly believe that if charging at point of care (general practice or A&E) is brought in, these costs will dwarf any cost savings from recouping treatment costs from migrants.

**"*A system where everybody makes a fair contribution to the NHS"*.** We would argue that the NHS was born out of the notion that *"good healthcare should be available to all, regardless of wealth."* [1] At its inception, in 1948, the then minister of health, Aneurin 'Nye' Bevan, outlined its three core principles: *"that it meet the needs of everyone, that it be free at the point of delivery, that it be based on clinical need, not ability to pay."* [1] These are the true overarching Principles that must be applied and not 'fair contribution'. Recent research conducted by the King's Fund and Ipsos MORI[2] has shown that these principles are still very much believed in today. It found that the UK public strongly supported the founding principles of the NHS – *"specifically access based on need rather than the ability to pay, that it is available to all, and of high quality"* – and moreover, they wished these principles to endure. Furthermore, we believe that 'fair contribution' is a very subjective principle and therefore inappropriate for an overarching principle.

***"A system that does not increase inequalities"*** – We believe that the changes proposed are in direct conflict with this principle. Any policy that charges some but not others, and that restricts access to services for certain groups of people, can only serve to increase inequalities. This is particularly so if those who are being excluded are already amongst the most marginalised and vulnerable in society. The changes proposed will affect some groups and not others. Those groups that it does affect (including British homeless people, those with mental health issues, and Black and Minority Ethnic (BME) groups) will have reduced access to healthcare, and consequently poorer health outcomes. Therefore it is necessarily the case, it is a logical certainty, that health inequalities will increase. Decision makers should have regard to this, particularly when balancing the outcomes of the Immigration Bill against the duty on the Secretary of State with regard to inequalities in the Health and Social Care Act.

In addition, we would argue that we should be striving not just to 'not increase inequalities', but instead to reduce health inequalities. The Marmot Report, *Fair Society, Healthy Lives*[3], stressed, "*tackling health inequalities was a matter of social justice, with real economic benefits and savings".* The UK Government's commitment to reducing Health Inequalities is evident, with Health Secretary Jeremy Hunt stating: *"Everyone should have the same opportunity to lead a healthy life; no matter where they live or who they are which is why we must continue to work to narrow the gap in health inequalities."*
*"We have set out the first ever specific legal duties on health inequalities for the NHS and I recently set out my challenge on reducing premature mortality."*[4] The Secretary of State,

NHS England and the Clinical Commissioning Groups all have a legal duty, under the Health and Social Care Act 2012, to reduce inequalities by improving the health outcomes of groups including the marginalised and vulnerable.

**We would also propose that several other fundamental principles need to be taken into consideration.**

**First, do no harm -** one of the principal precepts of medical ethics, which should be at the heart of decision making for any health provider.

**The right to health -** as outlined in Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR). Article 12 describes *"the rights of everyone to the enjoyment of the highest attainable standard of physical and mental health"*. The UN Committee on Economic, Social and Cultural Rights has stated that under ICESCR:

*"States are under the obligation to respect the right to health by...refraining from denying or limiting equal access for all persons, including...asylum seekers and illegal immigrants, to preventive, curative and palliative health services"*

The European Social Charter guarantees that *"Everyone has the right to benefit from any measures enabling him to enjoy the highest possible standard of health attainable"* and *"Anyone without adequate resources has the right to social and medical assistance".*

**Child first, migrant second** [5,6]
The importance of not allowing immigration status to take precedence over any child's well-being we feel is best summarised by the European Council:
*"A child is first, foremost and only, a child. This is the starting point for any discussion about undocumented migrant children. The status of the child is secondary and arguably, irrelevant."*[7]

**A system which promotes Public Health and does not negatively impact on it**
Public Health being defined as: *"The science and art of promoting and protecting health and well-being, preventing ill-health and prolonging life through the organised efforts of society."*[8]

**A system where existing service standards and guidelines (e.g. NICE guidance) are not being undermined.**

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**Question 2: Do you have any evidence of how our proposals may impact disproportionately on any of the protected characteristic groups[1]?**

**Response:**

Using the Equality Act 2010 definitions, we believe these proposals will impact disproportionately on several protected characteristic groups.

**People from Black and Minority Ethnic backgrounds (BME)** – We are concerned that these proposals will exacerbate discrimination and institutional racism. Checking entitlement, by its very nature, leads to a greater propensity for discrimination - a point raised in *'The identification and charging of Overseas Visitors at NHS services in Newham: a Consultation'*.[1] People from BME backgrounds who are European Economic Area (EEA) nationals are more likely than their white peers to have their entitlement questioned by those administering the system. This report found that there were episodes of staff, particularly front-line staff at GP practices, exhibiting discrimination, racism, and negative attitudes. It further highlighted that this was known to be a major barrier to accessing healthcare particularly for refugees and asylum seekers.[2]

These proposals will almost certainly impact disproportionately on refugees, asylum seekers and refused asylum seekers ('failed' asylum seekers), groups that are already particularly vulnerable due to political and social ostracision.[3, 4] The limited research available suggests that refused asylum seekers are a particularly vulnerable group in terms of health needs.[1,3,4,5,6,7] In general, morbidity amongst undocumented migrants is thought to be related to a combination of poor living conditions and general social disadvantage.[8] The cumulative effect of these factors results in a tendency for undocumented migrants' health to deteriorate over time.[9] Many will originate from countries with poor infrastructures, including disrupted/minimal healthcare systems, and may have taken dangerous and circuitous routes to the UK. Additionally, some may have spent time in refugee camps. All these factors could impact on undocumented migrants' health status both on arrival and in the future.[1,10]

The impact of the current charges on undocumented migrants' health has been well

[1] As defined in the Equality Act 2010: age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership, and pregnancy and maternity

documented. A report published by the Refugee Council[11] stressed that the employment of debt collectors to extract money for medical care, from those who are not able to pay, causes a great deal of distress and can create a significant barrier to accessing care, for some of the people most in need. Evidence from a qualitative study of 17 professionals from 14 different organisations who work with refused asylum seekers also testifies to the detrimental effect of the current charging system on this group,[5] which would only be exacerbated by the proposed changes.

Refused asylum seekers are not allowed to work and therefore cannot generate income, consequently refusing access to free healthcare is, in effect, denying access to care. If they do decide to take on the burden of a considerable debt, there is evidence that Trusts pursue them, in an often aggressive manner, even when they have no means of paying substantial hospital bills.[5,11] This results in a great deal of distress, despite it being fundamentally illogical, time consuming and expensive.

These barriers are on top of those already faced by refused asylum seekers when accessing healthcare. Language barriers,[9,11] concerns about confidentiality,[14] discrimination by members of staff,[1, 15] concerns about authority,[3] lack of knowledge with regard to UK health system and entitlements have all been cited as pre-existing barriers[3].

It was for these reasons, and many more that during a previous consultation on proposals very similar to these, the British Medical Association (BMA) and the Mayor of London, objected to the proposals. The former citing *"ethical, clinical and humanitarian grounds"* [12] and the latter feeling that it undermines the work that is being done to enhance social inclusion in London.[15]

**Age – Children**

As healthcare professionals, we are very concerned about the position of undocumented migrant children. Although the exemption for those that are 'Looked-After' still stands, children in families would be significantly and detrimentally impacted by the institution of charges for accessing Primary Care. Health protection is normally afforded to children via surveillance, screening and immunisation in the Primary Care setting in the form of, the Healthy Child Programme (HCP).[16] The Department of Health states that ***"****HCP is the early intervention and prevention public health programme that lies at the heart of our universal service for children and families"*. Their commitment to this programme has only just been reiterated.[17] Charging for Primary Care would create a barrier to promoting the health and well-being of children; of particular concern, is the impact charging could have on immunisation up-take. The National Institute of Health and Care Excellence (NICE)[18] has highlighted the wider implications that reduced immunisation up-take has on herd immunity for communicable diseases. Herd immunity helps protect those who have not been immunised and those in whom immunisation did not produce a degree of immune response sufficient to confer protection. From a public health perspective, it is important that the proportion of people vaccinated (vaccine coverage) reaches a certain percentage, which will protect the public against epidemics but there may still be some onward transmission of the disease. These vaccine coverage targets vary from disease to disease; for measles, the target vaccine coverage is over 95%.[19] Though our vaccination rate is rising, still only 91.2% of children at the age of two have received their first dose of the MMR vaccine.[20] In light of the rise in incidence of

measles cases, and the Chief Medical Officer contacting all GPs and Local Authority Directors of Public Health to inform them *"It is vitally important that as many children as possible are protected against measles by receiving both doses of MMR",*[21] these proposals seem detrimental to the health of both individual children and the population as a whole.

In general, these proposals seem to be at odds with the government's own commitment to an effective childhood immunisation programme with its aim to reduce the incidence of childhood infections. A commitment emphasised by the government announcing that *"increasing the proportion of children who have received all their immunisations"* is a primary care priority.[17] NICE,[18] in its recommendations on how to reduce differences in up-take, highlighted several groups as being at particular risk of not being immunised including *"those from some minority ethnic groups, those from non-English speaking families, and vulnerable children, such as those whose families are travellers, asylum seekers or are homeless".* Indeed, in a US study of newly arrived immigrants[22] (half of whom were refugees) 36% (range, 22% to 54%) were found, on carrying out measles, mumps and rubella serology, to be non-immune to at least one of the three diseases. In general, no or incomplete immunisations are known to be an issue for asylum seeking and refugee populations.[23,24]

On top of this, barriers to screening and surveillance can result in delays in diagnosis with subsequent exacerbations of conditions due to lack of intervention. The benefits of GPs being one of the key providers/facilitators of early intervention programmes are well documented.[25,26,27]

Any barriers to accessing primary care, such as charging, impacts on child morbidity and feasibly, mortality, as well as increasing the burden on the already over-stretched A&E services. There are also significant child protection implications from these proposals. Lack of automatic free access to the HCP affects the ability of services to identify problems in child health, development and safety,[17] and thus, the power of services to make an early intervention. It is vital for the health and well-being of children that these services be free and accessible to all children.

We would also argue that these measures are contrary to the UK's international and national legal obligations. The special place that children have in the world is enshrined in the United Nations Convention on the Rights of the Child (UNCRC)1989, ratified by the UK. It clearly stipulates that each state must ensure the rights of

*"each child within its jurisdiction without discrimination of any kind."*

Article 2.

*"In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration."*

Article 3

*"States Parties shall strive to ensure that no child is deprived of his or her right of access to such healthcare services."*

Article 24

The applicability of this to all children regardless of immigration status is further

emphasised in the Committee on the Rights of the Child's General Comment No. 6. Paragraph 12:

*"The enjoyment of rights stipulated in the Convention are not limited to children who are citizens of a State Party and must therefore, if not explicitly stated otherwise in the Convention, also be available to all children – including asylum-seeking, refugee and migrant children – irrespective of their nationality, immigration status or statelessness."*

The UK, therefore, has an obligation to ensure that no child is deprived of their access to healthcare; furthermore, the NHS has a specific duty to safeguard and promote the welfare of children, as outlined in UK law in Section 11(4) of the Children Act 2004, carrying on from the duties first enshrined in the Children Act 1989. The UK Border Agency (now the Home Office) is now under the same duty by virtue of section 55 of the Borders, Citizenship and Immigration Act 2009.

'Every Child Matters: Change for Children'[28] set out a national framework for change that centred around five outcomes, which were seen as key to a child's wellbeing. It saw local authorities working in partnership with the then Primary Care Trusts to achieve these outcomes. Even with the dissolution of Primary Care Trusts, the important role of Primary Care in Child Health is clear. The statutory guidance 'Working Together to Safeguard Children - A guide to inter-agency working to safeguard and promote the welfare of children' emphasises that: *"a wide range of health professionals have a critical role to play in safeguarding and promoting the welfare of children including: GPs, primary care professionals, paediatricians, nurses, health visitors, midwives, school nurses, those working in maternity, child and adolescent mental health, adult mental health and alcohol and drug services."* If these roles are critical then there cannot be any impediments to accessing them, especially if they are normally part of routine care.

We believe that if a child is not afforded free unhindered access to appropriate health services then they run the risk of suffering from increased disability and illness which could otherwise have been prevented.

**Pregnancy and maternity - Pregnant women**

We are concerned about the impact these proposal will have on pregnant women. We know that maternal health outcomes amongst migrant women are significantly worse than in the rest of the population.[29.] In the UK, late booking (after 20 weeks gestation) and missed antenatal appointments in general are risk factors for maternal death include.[30] Access to good ante-, peri- and post-natal care is crucial in the reduction of maternal and neonatal mortality.[31]

Vulnerable migrant groups are at particular liable to have poor maternal and child health. Social disadvantage, poor living conditions and BME backgrounds are all associated with significantly higher rates of maternal mortality.[30] This association between socio-economic status and poor outcomes extends to infant mortality with babies born in the most socially disadvantaged group having twice the infant mortality rate of the population as a whole.[32]

Furthermore, poor general health has a significant impact on maternal health outcomes for vulnerable migrants including conditions such as underlying heart disease.[30] In some migrant populations congenital health disease may remain undetected due to

lack of screening in their country of origin and lack of access to preventative strategies can lead to acquired heart disease. Female Genital Mutilation/cutting (FGM), prevalent in some communities, can pose a particular problem for pregnant women and in some cases, without access to health services, can result in obstructed labour with severe consequences for both mother and baby. In addition to this some women may be experiencing psychological and physical problems secondary to their experiences in their country of origin and en route to the UK such as physical injuries, rape and human trafficking. The Confidential Enquiry into Child and Maternity Health (CEMACH) report, recommended that because of the impact of these various co-morbidities it is essential that every newly arrived pregnant women should have a full medical assessment;[30] this should be carried out by a suitably trained doctor, which could include the women's GP.[31]

It is because of these risks that significant NHS resources are invested in promoting early engagement with services by vulnerable migrant women. Charging vulnerable migrant women for maternity care essentially undermines these strategies. We believe, with evidence to substantiate this, that charging for maternity care can result in barriers to their care and can act as a deterrent in accessing healthcare.

Research has found that the current charging system results in women being denied access to care because they are not able to pay for their treatment in advance of provision of services, staff are unaware of entitlements, or women have been deterred from accessing treatment due to a fear of incurring large debts.[1,5,11,33,34,35] The Joint Committee on Human Rights documented some of these breaches including an insistence of payment prior to the provision of care, rude and aggressive behaviour by Overseas Visitor Managers and threats to bring in debt collectors before a baby has even been born.[35] Project London, in a review of their London walk-in clinic, found that 68% of their pregnant service users had been unable to access antenatal care, with 25% not receiving any antenatal care by 18 weeks gestation, and a staggering 1 in 20 not having received antenatal care by 30 weeks gestation.[33] As stated before, there is clear evidence that failure to receive appropriate antenatal care puts women at risk of maternal death and complications at delivery.

The policies in place at the moment create financial disadvantages for trusts in providing care to vulnerable migrant women. Trusts are required to provide care to women who are chargeable and unable to pay but they are not reimbursed for maternity care provided to these women.

For pregnant women living with HIV, prompt access to antenatal care is vital, especially as many are only diagnosed during routine antenatal screening.[36] A national study, including 2003-2006, found with appropriate interventions mother-to-child-transmission occurred in 1.0% of cases (38/3695) and in only 0.8% of women who had been on treatment for at least 14 days prior to delivery.[37] In addition to ethical considerations of not aiming for the lowest level of mother-to-child transmission possible; costs of lifetime care for a child born with HIV are significantly greater than costs of the mother's antenatal care.

Charging for Primary Care Services will further impact on pregnant women as 83% of women first seek maternity care through their GP.[38] Charging for GP services could result in a significant delay in vulnerable migrants seeking access to maternity care or may lead to them not seeking it at all. Existing evidence shows that charging is

already denying women care.[1,5,11,33,34,35] We believe if access to free healthcare is further curtailed, both through changing the definition of ordinary resident and through charging for primary care, this will result in more mothers not engaging with services putting both mothers and babies at risk.

There is clear evidence that current policy has negatively impacted on pregnant women's health and well-being and that the outlined proposals will only make this situation worse. Furthermore, the consultation specifically targets maternity services for additional charges, even when non-EEA migrants have paid the levy. We also feel that the proposal to charge for maternity services for 'pre-existing' pregnancies is unworkable and ultimately, discriminatory.

We would also welcome a costs-benefits analysis of exempting maternity care from charging which takes into account the significant savings to be made from prevention and early treatment of complications amongst vulnerable migrant women and their babies.

**Sex - Women**

Even though access to sexual health clinics is exempt from these proposals, this does not take into account that GP services are also an important access point for advice regarding sexual health. Any restriction, via charging, to access to sexual health services is likely to have huge knock on effects; placing migrant women at more risk of unwanted pregnancies and sexually transmitted infections.[31]

Women who require a termination of pregnancy are chargeable under the current system and would remain so with these proposals. If migrant women are charged to see a GP they may not seek advice until late in their pregnancy and late terminations carry more risk. It is also felt that existing measures may put women under pressure to seek alternative, cheaper and illegal means of terminations putting them at greater risk of complications.[31]

It has been reported that an estimated 600 undocumented migrants a year are subject to domestic violence from their partner.[39] It has been known for quite some time that pregnancy is associated with an increased risk of domestic violence, with 30% of domestic violence cases occurring during pregnancy.[40] The 2004 CEMACH report outlined 19 cases of women who had been murdered by their partners, out of the 295 maternal deaths examined, with an additional 70 women who died showing features of domestic abuse .[30]

GPs are one of the key providers of support and healthcare for women experiencing domestic abuse. GP reports can also be used as evidence to support a claim for leave to remain in the country due to the need to escape an abusive relationship. Institution of charges will hinder GP access; women may be unable to obtain money, or be able to explain to borrow money, to pay for access to their GP and so may lose this valuable means of support.

**People with a disability**

As these proposals centre on a person's ability to contribute to the costs of their healthcare, those who are living with a pre-existing disabilities or health condition will be significantly more affected. In addition, we are concerned that the proposal, which

requires non-EEA migrants who have paid the health levy to pay a further contribution for specific services, could easily lead to discrimination against people with disabilities who require specialist and expensive treatment.

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## Who should be charged?

**Question 3: Do you have any views on how to improve the ordinary residence qualification?**

**Response:**

By changing the definition of ordinary migrant to "a non-European Economic Area (EEA) migrant (who is subject to immigration control) to have indefinite leave to remain (ILR)" there will be a significant increase in those who are vulnerable to charging and

restrictions. We cannot therefore support this change. We would also like the government to clarify the position of those with Discretionary Leave to Remain and Humanitarian Protection. As they have neither refugee status nor indefinite leave to remain but have been given limited leave to remain. It is unclear where this population would stand with regard to the changes; the fact that they might be unentitled to free healthcare, by virtue of not being ordinary resident, suggests this is an unfair and unworkable definition. A broad definition of ordinary residence, as is currently in use, which does not tie into a particular immigration status, avoids the risk of unintentionally excluding groups such as those with Humanitarian Protection and Discretionary leave to remain.

**Question 4: Should access to free NHS services for non-EEA migrants be based on whether they have permanent residence in the UK?**

**(Yes / No / Don't know)**

**Response:**

**No.**

Access must be based on clinical need and charging can act as a barrier to accessing healthcare as evidenced in question 2, thus, resulting in considerable and unjustifiable distress.

In addition, permanent residence reflects neither the commitment nor contribution of migrants to the UK. The consultation document states that the average time it takes to become a permanent resident in the UK is 5 years. However, there is significant variation in pathways to Indefinite Leave to Remain, this means that migrants can be living in and contributing to the UK for many years before they are actually entitled to access to NHS services.

As mentioned previously, we are concerned that victims of domestic abuse may be particularly vulnerable for the reasons outlined in question 2. If their permanent residence status is dependant on an abusive spouse/partner, it means that their access to NHS services will be obstructed when they may need them most.

**Question 5: Do you agree with the principle of exempting those with a long term relationship with the UK (evidenced by National Insurance contributions)? How long should this have been for? Are there any relevant circumstances under which this simple rule will lead to the unfair exclusion of any groups?**

**Response:**

The way the question is phrased might be read as implying agreement with charges for

certain migrant groups; we would like to stress that we do not agree with charges for any migrant groups.

We have no problem with those with a long-term relationship with the UK being exempt but we disagree that this should be evidenced by National Insurance (NI) contributions. Taking seven years of NI contributions as a basis for entitlement could lead to charging and restricted access to the NHS for long-term UK permanent residents who have been unable to work for reasons such as disability and caring responsibilities. To base entitlement on NI contributions is not only unnecessary but also likely to discriminate against some groups; therefore, it cannot be used as a determiner for NHS access. Applying this measure to the population as a whole would entirely undermine the core principles underpinning the NHS.

We also feel that it would be hard to implement this principle due to the inherent difficulties in distinguishing between 'expatriates' and those returning to live in the UK after a protracted period abroad.

**Question 6: Do you support the principle that all temporary non-EEA migrants, and any dependants who accompany them, should make a direct contribution to the costs of their healthcare?**

**Response:**

**No.**

Healthcare needs to be based on clinical need. The key tenets of the NHS are *"that it meet the needs of everyone, that it be free at the point of delivery, that it be based on clinical need, not ability to pay*[1]." Recent research, conducted by the King's Fund and Ipsos MORI[2] has shown that these principles still hold true today. It found that the UK public strongly supported the founding principles of the NHS – access based on need rather than ability to pay, availability to all and high quality – and wished these to endure. We do not support the use of 'fair contribution' as an overarching principle as it is at odds with principles underpinning the NHS. Also of note, while staying in the UK, migrants pay VAT and if they are working, income tax and NI contributions. Additionally, they may contribute through visa fees.

**References**


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**Question 7: Which would make the most effective means of ensuring temporary migrants make a financial contribution to the health service?**

**a A health levy paid as part of the entry clearance process**

**b Health insurance (for NHS treatment)**

**c Other – do you have any other proposals on how the costs of their healthcare could be covered?**

**Response:**

**c)**

We cannot support either of the above proposals, as there is no evidence base for a need for them. A report compiled by Doctors of the World, looking at data from their walk-in clinic over a seven-year period, found that average time that their service users had been living in the UK prior to attempting to access healthcare was three years.[1] Only 1.6% of people using the service had left their country of origin for personal health reasons. Similarly, the National AIDS Trust has found no association between immigration and HIV status. Migrants tended to come to the UK unaware of their HIV status and testing happen, on average, five years after arriving in the UK.[2]

After the last consultation, the Joint Committee on Human Rights (JCHR) noted that *"the Government has not produced any evidence to demonstrate the extent of what it describes as 'health tourism' in the UK"*[3] and the House of Commons Health Select Committee (HCHSC) *"were astonished that by the Department [of Health]'s own admission, these changes [were] introduced without any attempt at a cost-benefit analysis."*[4] We cannot see that anything has changed. We agree that a full cost-benefit analysis should have been done before the consultation was opened.

Both of these measures could potentially impact on student applications and tourism, leading to a reduction in the number of international students and tourists who make a contribution to the economy, and vastly outweighing costs to the NHS. There is also the impact on NHS staffing levels to consider.

We feel the focus should be on recouping costs from other EEA nations for the treatment of their citizens. This is an agreement that has already been made and just needs an efficient system to allow appropriate invoicing. States are bound to pay for their citizens, provided they are not working in the UK (in which case, costs are borne by the UK). This is surely the best place to start.

We would strongly disagree with introduction of either a health levy or health insurance. We feel the worst proposal is implementation of a health insurance model, which would come with a significant administrative burden, in addition to all the reasons outlined as evidence against the institution of either proposal.

Neither of these options will cover undocumented migrants living permanently in the UK. The charging system will still operate for them and will therefore continue to present barriers to healthcare for patients, without any apparent benefit to the NHS.

**References**


1. Access to healthcare in Europe in times of crisis and rising xenophobia" (Doctors of the World International Network, 2013) – the full report including all UK statistics can be downloaded at http://www.mdm-international.org/spip.php?article1205 (accessed 20th July 2013)
2. The National AIDS Trust. (2008). The Myth of HIV Health Tourism. NAT
3. Joint Committee on Human Rights (2007) *Tenth Report: The Treatment of Asylum Seekers.* London: Stationary Office
4. House of Commons Health Select Committee (2006) 'NHS Charges: Third Report of Session 2005-2006', HC 815-I, London: The Stationary Office Limited


**Question 8: If we were to establish a health levy at what level should this be set?**

a) **£200 per year**

b) **£500 per year**

c) **Other amount (please specify)?**

**Response:**

**c)**

The phrasing of this question appears to assume implicit agreement with the implementation of a health levy; we would like to stress that we do not agree in the implementation of a health levy for all the reasons outlined previously.

**Question 9: Should a migrant health levy be set at a fixed level for all temporary migrants? Or vary according to the age of the individual migrant?**

a) **Fixed**
b) **Varied**

**Response:**

a) **Fixed**

The phrasing of this question appears to assume implicit agreement with the implementation of a health levy; we would like to stress that we do not agree with implementation of a health levy for all the reasons outlined previously. In principle, a levy would have to be fixed in order to not introduce the possibility of discrimination against other characteristics such as disability, ethnicity, maternity and sex. If it is agreed that someone ought not to pay then the best way of ensuring this is by virtue of an exemption.

**Question 10: Should some or all categories of temporary migrant (Visa Tiers) be granted the flexibility to opt out of paying the migrant levy, for example where**

**they hold medical insurance for privately provided healthcare?**

**(Yes / No / Don't know)**

**Response:**

**No.**

The phrasing of this question appears to assume implicit agreement with the implementation of a health levy; we would like to stress that we do not agree with the implementation of a health levy for all the reasons outlined previously. If such a levy was implemented with an opt out for those with medical insurance, this could leave migrants vulnerable to accruing large debts. Furthermore, medical insurance policies do not always cover all services, for example unexpected costs associated with maternity and neonatal care.

In addition, the exemption of those who can afford health insurance for private healthcare would lead to placing the burden of paying the levy on only the poorest migrants. This seems illogical and would, again, increase inequalities and further marginalise these groups.

There is also additional administrative burden of having to run two systems in parallel.

**Question 11: Should temporary migrants already in the UK be required to pay any health levy as part of any application to extend their leave?**

**(Yes / No / Don't know)**

**Response:**

**No.**

Our belief is that there should be no health levy and our response below should not be construed as tacit agreement.

If a health levy were to be instituted, it should be required only as part of an initial application to enter the UK. Those already in the UK will have been contributing to the NHS through everyday taxation for a considerable amount of time. It is unreasonable to expect a health levy to be paid as part of an application to extend leave. A migrant application for an extension to remain in the UK, demonstrates commitment to stay in the UK in itself. In this setting, migrants should be able to access healthcare as any other resident.

**Question 12: Do you agree that non-EEA visitors should continue to be liable for the full costs of their NHS healthcare? How should these costs be calculated?**

**Response:**

**No.**

The current system of charging is not cost-effective. It creates significant costs both in terms of its impact on health and its associated costs and administrative burden.

According to the '*2012 review of overseas visitors charging policy*'[1],the largest category of chargeable 'visitors' affected by the current charging system are those migrants living in the UK without the required immigration documentation. These include many refused Asylum Seekers, some human trafficking victims, other vulnerable groups and visa over-stayers. As the review makes clear, these groups are largely unable to pay charges for healthcare they access. Time and money is lost trying to recoup costs from migrants and causes significant distress. Furthermore, migrants are deterred from accessing healthcare until they are seriously ill, as evidenced in question 2. This puts migrant health at significant risk and increases the likelihood of them needing to access more costly emergency treatment in the future. In the case of communicable diseases, there are wider public health risks, on top of individual health considerations, which the Department of Health acknowledged in their review.[1]

The definition of 'Health Tourism' given is: "any unpaid debts for chargeable NHS treatment" with the inclusion of "those who are residing here unlawfully and who receive emergency treatment but have no resources to pay for this". We question how this definition is in keeping with the common sense notion of 'Health Tourism'? If migrants are neither here for a short-term basis nor for the express purpose of receiving free NHS care, how can they be 'Health Tourists'? The current system captures a much broader group of patients, with both financial and health implications to the NHS.

**References**


1. International Policy Team. *2012 review of overseas visitors charging policy. Summary Report.* Department of Health, 2013.


**Question 13: Do you agree we should continue to charge illegal migrants who present for treatment in the same way as we charge non-EEA visitors?**

**Response:**

**No.**

We believe the current approach of charging undocumented migrants is detrimental to the health of the individual and the population as a whole and therefore, should not be continued. We would like to reiterate the point raised in the 2012 Review that undocumented migrants include many refused asylum seekers, some human trafficking victims, other vulnerable groups and visa over-stayers. The vulnerable nature of refused asylum seekers as a group is well documented,[1,2,3,4,5,6] along with the fact that they could not possibly afford to pay for their healthcare.[1] Pursuance of debts from people that have no money is extremely distressing and damaging[7]. It is also very costly from both a public health perspective and an individual health and wellbeing perspective, as charging acts as a deterrent for seeking care, resulting in delays in

presentation, diagnosis and treatment. Essential treatment is provided at a cost, which cannot be recouped. An approach, which aims to prevent illness or enable early diagnosis and treatment of conditions, is the best course of action for a health provider. It would be much more cost-effective to reduce barriers to healthcare access for this group.

In addition, the practice of charging vulnerable, undocumented migrants for their healthcare runs completely contrary to the overarching principles set out at the beginning of this document. It denies healthcare to those in need, it is unworkable and inefficient, actively increases inequalities and is generally ill advised.

**References**


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4. Harris R. *The Exclusion of Failed Asylum Seekers from Free NHS Care: a Policy Analysis and Impact Assessment.* International Health BSc Dissertation. London: UCL, 2005.
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**Question 14: Do you agree with the proposed changes to individual exemptions? Are any further specific exemptions required?**

**Response:**

The way this question is phrased might be read as implying tacit agreement with charges for other migrant groups. We would like to stress that we do not agree with charges for any groups.

We agree with the exemptions and welcome the continued existing exemptions as listed. There is also a need for further exemptions for the following three groups:

**1. Maternity services** should be exempted for the reasons outlined in question 2.

**2. People who have been granted humanitarian protection or discretionary leave.** The Home Office immigration rules[1] define humanitarian protection as:

*"A person will be granted humanitarian protection in the United Kingdom if the Secretary*

*of State is satisfied that:*

*(i) he is in the United Kingdom or has arrived at a port of entry in the United Kingdom;*

*(ii) he does not qualify as a refugee as defined in regulation 2 of The Refugee or Person in Need of International Protection (Qualification) Regulations 2006;*

*(iii) substantial grounds have been shown for believing that the person concerned, if he returned to the country of return, would face a real risk of suffering serious harm and is unable, or, owing to such risk, unwilling to avail himself of the protection of that country; and*

*(iv) he is not excluded from a grant of humanitarian protection."*

If a person fulfils this definition then he/she should have full and free access to healthcare.

Discretionary Leave to Remain is granted in cases where there are exceptional circumstances to justify doing so and these reasons should also entitle an individual to free and unhindered access to healthcare.

**3. Children defined as those under the age of 18**
Extending the current proposals to exempt all children, regardless of status, from charging for NHS treatment, in all areas, is the only way to safeguard and promote the welfare of children. We believe this should be obligatory in accordance with both National and International Law.

**References**

1. UK Immigration Rules - Section 339C.

## What services should we charge for?

**Question 15: Do you agree with the continued right of any person to register for GP services, as long as their registration records their chargeable status?**

**Response:**

Healthcare should be given on the basis of clinical need. We support the right of people to register with a GP but this should not be contingent on their registration recording their chargeable status.

**Question 16: Do you agree with the principle that chargeable temporary migrants should pay for healthcare in all settings, including primary medical care provided by GPs?**

**(Yes / No / Don't know)**

**Response:**

**No.**

'Chargeable' temporary migrants should not pay for healthcare in any setting as healthcare is a right and we believe these proposals will interfere with this right.

Primary healthcare plays a pivotal role in an effective healthcare system[1]**.** Creating a barrier to accessing primary healthcare will result in vulnerable groups being shut out of healthcare services altogether, until they become so ill they must present to A&E.

Areas of particular concern include:

**Preventative Medicine and Health Promotion**

Open primary care services are vital for public health. For Instance, it is not in the best interests of the population to be creating obstacles to immunisation as this leads to events that are harmful to population health such as the recent measles crisis in Wales[2].

Preventative healthcare and screening for conditions such as diabetes and hypertension are just as important in migrant populations as in the UK born population. Barriers to migrant populations accessing these services are not considered cost-effective.[3,4]

**Impact on Emergency Services**

Studies suggest that obstacles to accessing Primary Care can have knock on effects on emergency services, in terms of increased attendance.[5,6] There is evidence to suggest, that here in the UK, migrants who have been unable to access primary care services look to A&E to meet their health needs [7,9, 10,11,12,13] although some ailments would be more appropriately treated in Primary Care.[8]

Increased A&E utilisation is very concerning on several levels. Firstly the cost, GP consultations on average cost £20 compared with your average A&E attendance which is more in the region of £110.[14] Secondly, as discussed previously, for health providers, it has been known for some time that prevention and early diagnosis are the best approaches both in terms of individual health and cost effectiveness. Providing care for a health condition in extremis is a far more costly endeavour[15]. There is evidence that with the current system, refused asylum seekers are experiencing difficulty in accessing preventative care, resulting in a delay in treatment until their condition has worsened, which is detrimental to them and expensive to the NHS. [5,16,17,18]

In the climate of uncertainty that existed post 2004, even those fully entitled to access healthcare free of charge, such as asylum seekers and British Citizens, have been denied access, sometimes with catastrophic consequences. [18,6,19,20,21]

To date, there has been no cost-benefit analysis carried out on the impact of excluding Overseas Visitors from health services in the UK. We are aware that an

audit is currently being conducted but this will not be complete until after the deadline for consultation response submission and therefore will be unhelpful to this phase of the consultation. We would have welcomed the provision of this information prior to the consultation.

**Infectious Diseases and Public Health**

To ensure good public health, health services must be easy and free to access. The current charging system creates barriers as people are not aware that there are exemptions for certain medical issues such as communicable diseases. There is also the issue that most people present with symptoms with a wide differential diagnosis, requiring investigation prior to arriving at a diagnosis. This can lead to charges, with their inherent deterrent effect, in settings where they should not be applied.[9] This can also result in wider public health implications, in terms of undiagnosed communicable diseases and on-going transmission, and obstacles to any public health initiatives in place.

Even diseases covered by the exemptions such as HIV, TB and hepatitis B may be affected by these proposals as they could deter people from presenting with symptoms or attending screening through fear of discrimination, eligibility checks or links to immigration procedures.[10]

In the case of HIV, public health experts view offering testing in primary care as important in the attempt to diagnose people who are living with HIV before they become unwell. Reducing rates of undiagnosed and late diagnosed HIV will also prevent people from unwittingly passing their infection on to others. Anti-retroviral therapy leads to a reduction in viral load, and therefore in reduction in transmission both from person to person and from mother-to-child.[22]

In order to be effective, many public health initiatives require sustained activity and need to reach the entire population. Recent relaxation of public health measures as a consequence of budget cuts in Greece have led to outbreaks of diseases that had been previously well controlled.[23] Public health provision in the UK is already under sufficient strain given recent changes in funding and structure of services, and the measures proposed in this document would further damage the ability of existing services to provide effective care.

**Child Health**

As mentioned in question 2, health protection is normally afforded to children via surveillance, screening and immunisation in the Primary Care setting, in the form of Health Child Programme.[24] There are significant concerns on ethical, legal, and public health grounds for the health and well-being of undocumented migrant children if these proposals are implemented. Please see response to question 2 for the evidence base.

**Mental Health**

Those who are suffering from mental health issues are at risk of disengaging with services if they are charged for services, this could result in risk to themselves and others. This will only have a negative impact on the healthcare system as there is

a greater cost incurred if a condition worsens and culminates in an individual having to be detained under the Mental Health Act or admitted to hospital in crisis.

**Implications for Particular Vulnerable Groups**

Refused Asylum Seekers applying for support on health grounds, under the terms of Section 4 of the Immigration and Asylum Act 1999, will have a doctor's report as part of their evidence, which is often supplied by a GP. Access to this service would be jeopardized if Primary Care were subject to charging.

We have mentioned in question 2 our concerns with regard to victims of domestic abuse and the fact that primary care is one of their avenues for support and to obtain evidence to support an application for permission to stay in the UK.

**Plausibility of Administration**

It is hard to see how charges in primary care could be instituted without discrimination unless whole new systems were introduced. New systems could present data protection implications, additional costs and administrative burdens.

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**Question 17: Do you have any comments or ideas on whether, and if so how, the principle of fair contribution can best be extended to the provision of prescribing, ophthalmic or dental services to visitors and other migrants?**

**Response:**

The principles and evidence base outlined in response to other questions apply to all areas of health promotion and treatment and therefore we do not think that charging should be extended to these services.

**Question 18: Should non-EEA visitors and other chargeable migrants be charged for access to emergency treatment in A&E or emergency GP settings?**

**Response:**

**No.**

It is neither ethical nor feasible to charge for access to emergency treatment in A&E or

emergency GP settings.

Resources cannot be diverted to consider healthcare eligibility in an emergency setting due to the emergency needs that must be addressed. Adding a further administrative step in the A&E department to determine whether or not a person is eligible would lead to potentially harmful delays in emergency treatment provision which could affect all patients, whether chargeable or not. This would also inevitably lead to the refusal of care to persons who are chargeable which is unethical and goes against the principles outlined in this document, and as the General Medical Council clearly states in '*Duties of a Doctor'*, we are all obliged to *"make the care of your patient your first concern"*[1]

References


1. GMC. *The duties of a doctor registered with the General Medical Council*. General Medical Council, UK, 2013.


**Question 19: What systems and processes would be needed to enable charging in A&E without adversely impacting on patient flow and staff?**

**Response:**

There is no system that would make charging in A&E workable. In light of this consultation, the BMA have said, *"Doctors should spend their time treating patients and not acting as the arbitrators of whether patients are eligible to receive NHS care."*[1]

To do this would create a new administrative burden, it is inevitable that some people will attract greater attention to questions –people from BME backgrounds, those for whom there is a clear language barrier or who generally 'appear foreign'. This will lead *to "discrimination in frontline service delivery on an unprecedented scale"*[2].

References


1. BMA. *Overseas visitor NHS charges require more thought, warn doctors leaders.* British Medical Association, UK, 2013.
2. Sarah Radcliffe. *Five points which must not be lost in the debate on NHS access.* The National AIDS Trust, 2013.


**Question 20: Do you agree we should extend charges to include care outside hospitals and hospital care provided by non-NHS providers?**

**Response:**

No.

Some of these services are set up to meet the needs of vulnerable people who have difficulty accessing NHS services such as homeless people and destitute asylum seekers. Charging for these services would make these harder to reach groups even

less likely to engage with any services.

**Question 21: How can charging be applied for treatment provided by all other healthcare providers without expensive administration burden?**

**Response:**

It cannot, and there is no evidence that it is indicated. In addition, it would create significant data protection issues as more and more agencies have access to personal information.

## Making the system work in the NHS

**Question 22: How else could current hospital processes be improved in advance of more significant rules changes and structural redesign?**

**Response:**

As we have stated before, the government should first focus on recouping costs through existing agreements, before turning their attention to non-EEA nationals. EEA member states have agreed to pay the UK government for EEA nationals, however the government admits that costs are not always being claimed back from the EEA Member state involved.

**Question 23: How could the outline design proposal be improved? Do you have any alternative ideas? Are there any other challenges and issues that need to be incorporated?**

**Response:**

Generally we feel that this is an extremely costly, unworkable and unethical proposal, which if implemented, would hinder the function of the NHS and negatively impact on the health of migrants and the population as a whole.

For each core component outlined in your associated documentation, we have found concerns and issues:

***"Initial NHS registration should include a review of eligibility for free treatment"***

If this were the case, then it would involve everyone being re-registered and having his or her eligibility checked, an extremely costly and intrusive measure. People would be deterred from re-registering, resulting in a decline in people attending primary care services and a diminished impact of public health interventions. Surely the follow-on stage, would be requiring everyone to show ID on accessing services, something many residents would not welcome. We feel this will present a significant hurdle to access of healthcare services for the whole population.

***"Relevant information is accessible from other government agencies"***

We are extremely concerned about any plans to link up NHS personal data with information about immigration status and NI contributions. There appears to be no evidence base to justify taking such a risk with the nation's personal data. As the NHS England Confidentiality Policy states, an NHS Number is Person-Identifiable information and must be treated as confidential[1]. The plan would be completely at odds with data protection principles outlined in Data Protection Act (1998) and Article 8 of the Human Rights Act (1998). The latter act refers to an individual's "*right to respect for their private and family life, for their home and for their correspondence";* public authorities should not infringe on this right.

With loss of confidentiality, a significant concern is that the doctor-patient relationship will be undermined and this has been voiced in previous consultation.[2]. Many migrants will be discouraged from seeking healthcare, whether they are entitled to it or not.

***"NHS numbers and related personal records should differentiate chargeable and exempt persons. They may also differentiate temporary migrants who may have time limited eligibility through the new migrant health levy, and EEA citizens for whom reimbursement may be claimable from their home country."***

Even if it were legal to data share in this manner, and the public were happy to have their personal data shared with the Home Office, it would be extremely costly to implement and then keep up to date, in a useful way, given the changing nature of some people's immigration status.

***"The initial 'NHS registration' could be separate from, and ideally precede, registering with a specific GP practice."***

As the Department of Health documentation points out, everyone would have to be re-registered; this could only be extremely costly and intrusive.

***"Eligibility information linked to the personal record/number should be accessible by all subsequent providers of treatment, in particular elective referrals from GPs, dentists and emergency hospital admissions."***

Again, there is no evidence to support that this necessary and the sharing of personal information in this manner leads to a greater risk of data protection infringement.

***"There should been an appropriate and integrated set of new financial and other contractual incentives to maximise the number of patients who are appropriately charged, and to maximise revenue recovery from appropriately charged patients. In particular hospitals should not be liable for unrecoverable costs of providing emergency treatment."***

We cannot see how incentives to 'maximise' charging could be instituted without opening the door to bias and discrimination. Relationships between health services and their patients would be compromised and trust undermined.

We do however agree that hospitals should not be liable for costs of providing emergency treatment.

***"The process of recovering charges from visitors could be managed on a pooled basis taking advantage of more professional systems and expertise. "***

For the data protection reasons outlined above we would not welcome third parties having access to personal information.

**References**


1. NHS England. Confidentiality Policy. NHS England, 2013. Available at http://www.england.nhs.uk/wp-content/uploads/2013/06/conf-policy-1.pdf
2. Global Health Advocacy Project. Proposals to Exclude Overseas Visitors from Eligibility to Free NHS Primary Medical Services. 2008.


**Question 24: Where should initial NHS registration be located and how should it operate?**

**Response:**

No response

**Question 25: How can charges for primary care services best be applied to those who need to pay in the future? What are the challenges for implementing a system of charging in primary care and how can these be overcome?**

**Response:**

The challenges for implementing a system of charging in primary care is unethical, discriminatory, increases the administrative burden, is not cost effective and is entirely unworkable.

It is unclear from the documentation provided how much patients will be charged for primary care access and how these rates will be set. We feel that any system would be open to discrimination against groups.

The system is, at its heart, unethical. The only person who should be deciding if a treatment is 'immediately necessary' is the doctor after he/she has seen the patient. This is not something that administrative staff can and should be expected to judge, as we are sure they will agree. Furthermore, doctors, via the BMA, have voiced their opposition to acting as the *"arbitrators of whether patients are eligible to receive NHS care."*[1]

The knock on effect of any barriers to primary care access will inevitably be people being forced to attend A&E, both those now presenting with a more serious illness due to lack of access to healthcare, and those with less critical health needs which still need to be met and would ordinarily be dealt with in the primary care setting. We do not see any accompanying proposals for expansion of A&E services to cope with this

anticipated increase in demand for services.

We must also consider those in the NHS workforce who will be responsible for implementing the system who may themselves be subject to the same rules.

**References**

1. BMA. *Overseas visitor NHS charges require more thought, warn doctors leaders.* British Medical Association, UK, 2013.

**Question 26: Do you agree with the proposal to establish a legal gateway for information sharing to administer the charging regime? What safeguards would be needed in such a gateway?**

**Response:**

**No.**

We do not agree that there should be a legal gateway for information sharing and there should be no transfer of personal information or data to any immigration bodies. Health services should remain independent of immigration controls and sanctions. We feel that to have an information-sharing gateway would be contravening data protection principles. We believe that the increased number of agencies in such a process would be more likely to lead to a breach of confidentiality. We would urge you to reconsider the implications of this for everyone.

Implementation of immigration sanctions on those who have incurred a debt in the UK is likely to increase the use of smugglers accessing the UK through non-legal means. There is a risk that immigration sanctions could negatively impact on individuals fleeing their country due to a well-founded fear of persecution and who would be entitled to apply for asylum under international law.
Immigration sanctions could also impact on UK-resident children or elderly people, who are dependent on a person that has been refused entry. Ability of these groups to access services, which they are entitled to, may be dependent on them entering the country accompanied by the person refused entry.

Finally, the proposal to refuse entry to people who owe money to the NHS does not make sense, as their inability to enter the UK would make it more difficult for them to pay and for the debt to be recouped.

## Recovering Healthcare Costs from the European Economic Area (EEA)

**Question 27: Do you agree that we should stop issuing S1 forms to early retirees and stop refunding co-payments and if not, why?**

**Response:**

No comment