ILPA response to the Department of Health consultation: Sustaining services, ensuring fairness: A consultation on migrant access and their financial contribution to NHS provision in England July 2013

Introduction

ἀσκέειν, περὶ τὰ νουσήματα, δύο, ὠφελέειν, ἢ μὴ βλάπτειν[1]

The Immigration Law Practitioners' Association (ILPA) is a professional membership association the majority of whose members are barristers, solicitors and advocates practising in all aspects of immigration, asylum and nationality law. Academics, non-governmental organisations and individuals with an interest in the law are also members. Established over 25 years ago, ILPA exists to promote and improve advice and representation in immigration, asylum and nationality law through an extensive programme of training and disseminating information and by providing evidence-based research and opinion. ILPA is represented on numerous government, including Home Office, and other consultative and advisory groups. Many individuals and organisations have been generous enough to share with us their responses in draft and for this we are very grateful. ILPA is also responding to the Home Office consultation.

In the case below, determined during the lifetime of this consultation, the Home Office had at the outset accused the appellant of health tourism.

***[…] (health claim: ECHR Article 8)* [2013] UKUT 00400 (IAC), 24 July 2013**

[…][2]… lived alone in Nigeria after being widowed … She was able to come to the United Kingdom in 2004 having secured, in the face of fierce competition, a scholarship … Soon after arriving in the United Kingdom to commence her studies… the appellant was diagnosed with end stage kidney failure. It is now accepted and no longer in dispute that she was unaware of this potentially fatal illness, or even that she was unwell at all, until after her arrival. The evidence establishes that to be unsurprising as the nature of that condition is such that a person in the claimant's position would most likely not have noticed any symptoms. …The claimant required dialysis…to remain alive … Her leave was progressively extended and, despite having to undergo dialysis several times each week, she graduated in 2008. Although granted a final extension of leave… so that she could attend her graduation ceremony, thereafter the respondent has refused all subsequent applications for further leave to remain…

[1] Hippocrates, ἐπιδήμιος (*Of the Epidemics),* c. 430 BC.
[2] We have omitted the name in this public submission.

In July 2009 the claimant received a kidney transplant and thereafter required carefully monitored medication to ensure that the level of that medication in her body is maintained at an appropriate level so that the transplanted organ is not rejected. Quite apart from that, monitoring is essential as too high a level of that medication in the body can prove fatal. She will always remain particularly at risk of infection, … While the claimant remains in the United Kingdom her life expectancy and her quality of life will be normal. It is, now at least, accepted by the respondent that she would not be able to access treatment in Nigeria and so would die within weeks. That is not because appropriate treatment and living conditions are not available in Nigeria but because she would not be able to afford to pay for them…

The issue at that appeal was a simple one but it was also a stark one: Was the refusal to grant leave, with the accepted consequence that the claimant would die soon after removal, such as to breach the claimant's right to respect for her private life, as protected by article 8 of the ECHR, or was it a proportionate interference with that right, given that the claimant is not a national of this country and had been admitted for a temporary purpose which has now been concluded?...

The appeal came before First-tier Tribunal Judge […] on 21 November 2012….the judge… allowed the appeal. Our task is to examine the challenge brought by the respondent to that decision…The judge summarised the respondent's case as it was argued before him as follows: "…. [The respondent's representative] *conceded that she could not afford the treatment in Nigeria and would therefore inevitably die… It was however proportionate to remove her"*[3]

The evidence demonstrated that the Home Office was wrong to accuse the appellant of health tourism. The Home Office then resisted the conclusion that were the appellant returned to Nigeria she would die within weeks from kidney failure. The evidence showed that the Home Office was wrong. For cases started after 1 April 2013, there has been no legal aid for immigration, as opposed to asylum, cases and thus it is very likely that there would have been no successful challenge to the accusation of health tourism. The Home Office then argued that the appellant's death was a proportionate price to pay for immigration control. This is a question that falls to be answered by reference to the law on Article 8 of the European Convention on Human Rights. Again, for cases started after 1 April 2013 there is no legal aid to assist an appellant in putting a case and this appellant, given her straitened circumstances, would have had to represent herself and herself make the case as to why she should be allowed to live. Our reading of the case is that were the proposals in the paper to be brought into force this appellant would continue to receive such elements of her treatment as are saving her life.

We invite the Department of Health to consider in the light of this example whether it wishes to become more closely involved in immigration control as is proposed in this paper.

We consider that the proposals will have the following effects:

i) They will lead migrants whose skills mean that they have a choice of destination to choose countries other than the UK;
ii) They will result in persons entitled to at least some health care, even if this is only on an emergency basis, not accessing the health services at all, including not taking their children to the health services. Decisions about

[3] See endnote.

> whether to present for health care will be made on the basis of self-diagnosis, with a strong incentive to consider whether one can struggle on. Some people will fail to diagnose serious conditions. Others will not present at health services until their condition has deteriorated and they have become a medical emergency.

Do these accurately reflect policy intentions? We do not consider that they are defensible given the suffering of the individual and the risks to public health. In addition, as set out in our response hereto we are unpersuaded that the proposals will save money.

Overarching principles

Question 1: Are there any other principles you think we should take into consideration?

Yes.

First, we do not consider that the proposals are compatible with the principles set out in the consultation for the reasons set out in this response. Among those not having access and suffering inequalities will be British citizens, settled persons and EEA and foreign nationals entitled to access the National Health Service.

A system that ensures access for all in need

Persons in grave need of health care will chose not to present for it. Persons eligible for health care will be wrongly denied it, often because they have been unable to prove their eligibility. Changes in law and policy will result in persons it was intended be eligible for health care not being eligible.

The combination of these checks, the proposals for landlords to check their tenants and existing checks, such as those carried out by employers and educational institutions, amount to a system of identity checks for foreign nationals. What this means in practice is a system of identity checks for all, since it is necessary for British citizens or persons with permanent residence to prove that they are lawfully present in the UK. Aneurin Bevan made this point in the context of access to the National Health Service:

> *However, there are a number of more potent reasons why it would be unwise as well as mean to withhold the free service from the visitor to Britain. How do we distinguish a visitor from anybody else? Are British citizens to carry means of identification everywhere to prove that they are not visitors? For if the sheep are to be separated from the goats both must be classified…*"[4]

We recall the Home Secretary's introduction of the Identity Documents Bill at second reading:

[4] *In Place of Fear*, Bevan, A., (1952), chapter 5.

> *The national identity card scheme represents the worst of government. It is intrusive and bullying, ineffective and expensive. It is an assault on individual liberty which does not promise a greater good.* [5]
>
> …
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> *We are a freedom-loving people, and we recognise that intrusive government does not enhance our well-being or safety. In 2004 the Mayor of London promised to eat his ID card in front of*
>
> > *"whatever emanation of the state has demanded that I produce it."*
>
> *I will not endorse civil disobedience, but Boris Johnson was expressing in his own inimitable way a discomfort even stronger than the discomfort to be had from eating an ID card. It is a discomfort born of a very healthy and British revulsion towards bossy, interfering, prying, wasteful and bullying Government.*[6]

The consultation paper is wrong in suggesting[7] that National Health Service funding was founded upon a model "based on our established, permanently resident population". It was not, as Aneurin Bevan made explicit in the passage that precedes the one quoted above:

> *One of the consequences of universality of the British National Health Service is the free treatment of foreign visitors. This has given rise to a great deal of criticism, most of it ill-informed and some of it deliberately mischievous. Why should people come to Britain and enjoy the benefits of the free Health Service when they do not subscribe to the national revenues? So the argument goes. No doubt a little of this objection is still based on confusion about contributions … The fact is, of course, that visitors in Britain subscribe to the national revenues as soon as they start consuming certain commodities…*[8]

A system that ensures access for all in need must ensure that all individuals receive both immediately necessary and urgent treatment as defined in the evidence document[9]. Without this, individuals suffer, there is the risk of increased costs of providing treatment for a more serious condition at a later date and public health may be jeopardised.

A system where everybody makes a fair contribution to the NHS

According to the consultation paper the proposal is that migrants should pay an additional sum for their health care. Not so. What is proposed is that migrants should pay an additional sum for their health care and that of other migrants.

The National Health Service is currently paid for through a system of general taxation, from each according to his/her liability to taxation to each according to his/her needs to use the service[10].

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[5] HC report 9 Jun 2010: Column 345.
[6] *Op. cit.* Col 350.
[7] Paragraph 2.10.
[8] *In Place of Fear*, Bevan, A (1952), chapter 5.
[9] *Op.cit* page 9.
[10] *Review of overseas visitors charging policy, Summary report*, Department of Health, April 2012, paragraph 7.

The proposal that a group be singled out and its members required to support each other is here applied to migrants. A similar approach could be taken to the elderly, or those having children, or those with chronic conditions.

There are also points in the paper that envisage the National Health Service as a contribution-based system. These appear to be new conceptions of the National Health Service with implications going far beyond the extent to which it does or does not treat migrants. They could properly be made the subject of a consultation aimed far more broadly than the current one.

Not everybody makes a contribution to the National Health Service now. Babies and children do not and some children, including those who have made the most demands upon the health service in their childhoods, do not reach adulthood. Some severely disabled persons never make a contribution. Similarly with some persons with caring responsibilities. Persons who remain long term unemployed may never get the opportunity to make a contribution. As identified in the evidence paper, migrants are as likely, and given their demographic profile, may be more likely, than British citizens and the settled to contribute more than they put in[11].

Without a robust definition of fairness, such as is not found in the consultation paper, this principle is not meaningful.

A system that is workable and efficient and ***A system that does not increase inequalities***

The Health and Social Care Act 2012 placed duties upon the Secretary of State[12] and on Clinical Commissioning Groups[13] to go beyond not increasing health inequalities and to reduce health inequalities[14] . These obligations are not currently being met[15]. The principles should align with those obligations.

It is stated that "The role of NHS staff should not extend to immigration control, and clinicians should not be diverted from treating patients." Efficiency is also mentioned. For the reasons set out in this response we consider that a system of identity checks for all is costly and inefficient and will result in National Health Service staff being involved in immigration control and identity checks.

We have seen in the past year the Home Office subcontract to Capita Plc. to text and telephone persons who are allegedly migrants with no leave telling them to leave the UK. British citizens, nurses, investors with a million pounds invested in the UK, all have been recipients of these texts. Which is no surprise. Capita has been

[11] *Evidence to support review: policy recommendations and a strategy for the development of an Impact Assessment*, Department of Health, July 2013, page 14 and the references cited therein. See also Migration and health in an increasingly diverse Europe', Health in Europe 5, Rechel, B. et ors, *The Lancet*, Vol 381, April 6, 2013, pp1235-1243.
[12] National Health Service Act 2006, s 1C.
[13] National Health Service Act 2006, s 14T.
[14] Health and Social Care Act 2012, section 62(4); National Health Service Act 2006, s 1C, 13G and 14T.
[15] See, for example, *Growing up in the UK – Ensuring a healthy future for our children*, British Medical Association (2013).

working from the Home Office database which both reflects the complexity of current immigration law and is not up to date[16].

As set out below, the proposed system would increase inequalities, both among the population whose eligibility is limited by the proposals and the British or settled persons, EEA and foreign nationals entitled to access to the National Health Service.

Annexe B identifies "Resident British nationals" for whom there will be "(n)o change - will continue to have automatic entitlement to free NHS services and will not be subject to extensive entitlement checks and challenges" but, for the reasons given by Aneurin Bevan in the comments cited above, how are they to be identified without such checks and challenges? The Annexe makes no mention whatsoever of those settled in the UK: persons with the right of abode, or indefinite leave to remain. Are they to be spared "extensive entitlement checks and challenges"? How?

In recent weeks we have seen the Home Office launch a campaign with advertisements on vans in particular London boroughs saying that there are 106[17] "illegal immigrants" in the area and advising those persons to send a text to get in touch with the authorities to arrange to "go home" or face arrest. Following a legal challenge based on the Government's failure to comply with the public sector equality duty under the Equality Act 2010, the Government confirmed that if any further campaigns of a similar nature are planned, they will carry out a consultation with local authorities and community groups[18].

Both the Capita exercise and the campaign involving the vans have been of questionable legality and the subject of considerable controversy[19]. Both are object lessons in how difficult it is to produce a workable and efficient system against the backdrop of an enormously complex immigration system, longstanding problems in Home Office record keeping and delays and backlogs in immigration casework. Both are object lessons in how a failure to promote equality can leave people, be they

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[16] See further *Capita's work for the UK Border Agency*, Oral and written evidence *29 January 2013, Paul Pindar, Chief Executive, Andy Parker, Joint Chief Operating Officer, and Alistair MacTaggart, Managing Director, Secure Border solutions, Capita Plc* , report of the Home Affairs Select Committee HC 914-I, published on 11 April 2013.and ILPA's August 2013 response to the Home Office consultation ***Strengthening and simplifying the civil penalty scheme to prevent illegal working.***

[17] In all the areas the same figure "106 arrests" was used, a matter that is now one of the subjects of an investigation by the Advertising Standards Authority.

[18] *Home Office Agree Never To Run Van Adverts Telling Migrants To Go Home Again Without Consulting,* Press release by Deighton Pierce Glynn solicitors of 12 August 2013.

[19] Examples include: *Capita's work for the UK Border Agency, op.cit, supra. 'You are required to leave the UK': Border Agency contractor hired to find illegal immigrants sent them TEXTS"* Daily Mail 11 January 2013, available at http://www.dailymail.co.uk/news/article-2260667/UK-Border-Agency-contractor-hired-illegal-immigrants-send-TEXTS-warning.html#ixzz2bm4JCfg2 (accessed 12 August 2013); ICO to investigate SMS messages sent to immigrants by Capita, Computer World 15 January 2013; *Nigel Farage attacks Home Office immigrant spot checks as 'un-British'*, The Telegraph, 2 August 2013; *Vince Cable MP*, BBC 28 July 2013, available at http://www.bbc.co.uk/news/uk-politics-23481481 (accessed 12 August 2013), *Bishops condemn Home Office 'go home' campaign*, Ekklesia, 12 August 2013, available at http://www.ekklesia.co.uk/node/18785 (accessed 12 August 2012), non-governmental organisations such as Show Racism the Red Card (see http://www.srtrc.org/news/news-and-events?news=4511 accessed 12 August 2013) and Liberty *"Go Home" vans, nasty racist and likely unlawful* 1 August 2013, see https://www.liberty-human-rights.org.uk/news/2013/go-home-vans-nasty-racist-and-likely-unlawful.php (accessed 12 August 2013).

persons under immigration control or British citizens, vulnerable to abuse and victimisation.

The principles of a workable system and one that does not increase inequalities support each other and addressing health inequalities can bring "real economic benefits and savings[20]. The Government has long been on notice of the need to undertake a cost benefit analysis of charging for health care. The House of Commons Health Select Committee said back in 2006 that its members:

> *…were astonished that by the Department's own admission, these changes* [were] *introduced without any attempt at a cost-benefit analysis*[21]

Such cost benefit analysis as has been carried out does not appear to support charging. The evidence paper says that the effect of the charges deterring persons from coming to the UK is unlikely to exceed 0.5% of Gross Domestic Product in a given year.[22] But 0.5% of Gross Domestic Product in 2012 was eight billion pounds.[23] If, as per the consultation document, charges levied will total about one billion and will not all be collected, then it would appear that the costs look set starkly to outweigh the financial benefits. What is the point of spending funds the National Health Service does not have in levying charges that it cannot recover?

We emphasise here, as at various points in this response, that very far from all those whom it is proposed to charge have a biometric residence document. Persons have an enormous variety of (non-biometric) different documents evidencing entitlement. Nothing in the consultation paper suggests that the extent of the complexity of verifying entitlement has been adequately communicated or understood.

Additional principles

We suggest the following:

- The core principles of the service as set out in the National Health Service constitution:

1. The NHS provides a comprehensive service, available to all.
2. Access to NHS services is based on clinical need, not an individual's ability to pay.
3. The NHS aspires to the highest standards of excellence and professionalism.
4. The NHS aspires to put patients at the heart of everything it does.
5. The NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities and the wider population.

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[20] *Fair society, healthy lives: the Marmot Review: strategic review of health inequalities in England post-2010*, Marmot, M., 2010. Accessed 22 August 2012 at http://www.marmotreview.org/AssetLibrary/pdfs/Reports/FairSocietyHealthy

[21] House of Commons Health Select Committee (2006) 'NHS Charges: Third Report of Session 2005-2006', HC 815-I, London: The Stationary Office. See also *Early Action: Landscape Review*, National Audit Office 2013.

[22] Department of Health, *Evidence to support review 2012 policy recommendations and a strategy for the development of an Impact Assessment*, July 2013, page 20.

[23] Gross Domestic Product for 2012 was £1,623.48 billion.

6. The NHS is committed to providing best value for taxpayers' money and the most effective, fair and sustainable use of finite resources[24].

- First, do no harm.

- The well-being of people is paramount (a principle highlighted in the Department of Health guidance on ordinary residence[25]).

- The rights and best interests of the child: the duties imposed upon the National Health Service and others to safeguard children and promote their welfare under section 11 of the Children Act 2004 and section 55 of the Borders, Citizenship; and Immigration Act 2009 are respected.

- The goal of eliminating child poverty is supported.

- Human rights, including the right not to be subject to inhuman or degrading treatment, are respected.

- Persons in the UK, including British nationals and settled persons continue to be free from routine identity checks.

- Existing service standards are met. (For example, the operational standard that 95% of Accident and Emergency patients should be admitted, transferred or discharged within four hours[26].)

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

This is the wrong question given that the duty is to reduce inequalities[27] rather than merely not to exacerbate them. The proposals will not reduce health inequalities. They will exacerbate them.

See response to question one above about the Capita texts and the Home Office vans campaign.

The proposals may affect members of what the consultation paper describes as "protected characteristic groups" because they mean that these persons are not entitled to health care or because they deter them from obtaining healthcare to which they are entitled[28]. A survey of 1449 people who visited the charity Doctors of the World in London found that 73% of these persons were not registered with a

[24] See *The NHS Constitution for England*, 26 March 2013, accessed 22 July 2013 at http://www.nhs.uk/NHSEngland/thenhs/about/Pages/nhscoreprinciples.aspx See further 'Founding Principles', Delamothe (2008) *British Medical Journal*, Vol 336, 31 May 2008, pp 1216-1218.
[25] See *ORDINARY RESIDENCE: Guidance on the identification of the ordinary residence of people in need of community care services, England , Department of Health, April 2013*. Accessed 25 July 2013 at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/185851/Guidance_on_the_identification_of_the_ordinary_residence_of_people_in_need_of_community_care_services__England_V2.pdf
[26] Gateway reference: 00062.
[27] Health and Social Care Act 2012, s 62(4); National Health Service Act 2006, s 1C, 13G and 14T.
[28] See *First do no harm: denying healthcare to people whose asylum claims have failed*, Kelly, N. & J. Stevenson, 2006, London, Oxfam and Refugee Council .

General Practitioner even though they were eligible for registration and that some 20% were deterred from seeking care for fear of the immigration control consequences[29]. This is in line with the experiences of ILPA members working with poor migrants.

See also the response to question 22 below.

The quality of the equality impact assessment in the consultation in a cause for concern. The understanding of indirect discrimination is poor. To take just one example as an illustration, it is assumed that because a person's status as a carer is not a condition of their access to the National Health Service, there will be no discrimination against carers. No consideration is given to the possibility that a carer will have been unable to work and thus to pay national insurance contributions. These examples can be multiplied. We suggest that the assessment be undertaken again, by experts, in the light of the responses received to this consultation.

Insofar as poor migrants live in poor areas, in poor housing, or work in exploitative environments, where they are poorly paid, they are likely to come into contact with poor British citizens and settled persons also living in that poor housing or work in those environments. Insofar as the proposals affect migrants' access to healthcare in respect of infectious diseases, they are likely disproportionately to affect those poor British citizens and settled persons. Thus not merely failing to reduce inequality but exacerbating existing inequalities. This relates directly and indirectly to protected groups, and to those affected by other inequalities.

Imposing charges hits those who have least money to pay hardest. These are also the people least likely to possess documents such as passports (because they cannot afford them and/or not need them because they cannot afford to travel.) Many of the protected characteristics are also relevant to a person's ability to speak up for themselves and negotiate complex bureaucracies. Those least able to negotiate officialdom will be hit hardest by the new bureaucracy[30]. See also the response to question 22 below.

Disproportionate impacts:

Black and minority ethnic people and people from specific nationalities – Persons under immigration control are by definition not British citizens and the proposals will reduce the likelihood that they obtain the healthcare that they need, including healthcare to which they are entitled. Black and minority ethnic people who are EEA nationals are more likely than people not from such groups to have their eligibility questioned.

It is also the case that nationals of particular countries predominate among applications from that country. Those in countries where average earnings are low

[29] Doctors of the World UK *The importance of equitable access to healthcare for people in England: a policy briefing*, 2013, see http://www.appgmigration.org.uk/sites/default/files/Doctors%20of%20the%20World%20-%20access%20policy%20briefing%2009072013.pdf (accessed 23 August 2013).

[30] See Stagg, H.R. et. al., *Poor uptake of primary healthcare registration among recent entrants to the UK : a retrospective study*, 2012;2:e001453, doi :10.1136/bmjopen-2012-001453.

compared to the UK and where the currency is weak against that of the UK will face greater barriers in entry clearance applications.

Disabled people and the elderly – Disabled people are more likely to struggle to find health insurance and to have to negotiate complex exclusions if they do obtain it. Similarly for elderly people. The groups may also be disadvantaged if they have to pay for specific services in addition to paying any levy.

Pregnancy and Maternity – It is suggested in the consultation that additional charges would be levied for maternity services. We identify a risk of harassment in the context of identifying "pre-existing pregnancies". Pregnancy is not an illness and is thus arguably one area where people are most likely to attempt to manage alone. We have seen instances of this and there is evidence to support it in research among undocumented migrants[31]. Research has identified that some 83% of women first seek maternity care through their General Practitioner[32]. In their cross-European study, Doctors of the World found that on average 79% of respondents were not accessing antenatal care[33]. There is evidence, including from the report *Treatment of Asylum Seekers* by the Joint Committee on Human Rights, that charges deter pregnant women from getting medical help or lead to their being denied help[34]. There is evidence that starting antenatal care after 20 weeks gestation is a risk factor for maternal death, as is not attending antenatal appointments, and screening[35]. There are also risks to the health of the child, and of increased infant mortality[36].

Gender – Women will be disproportionately affected by the pregnancy and maternity provisions. Women are less likely than men to have made seven years of National Insurance contributions during the same period of residence in the UK as men.

Women are more likely to be victims of domestic violence than men[37] and thus to be left without entitlement in the case of relationship breakdown on these grounds. Doctors may be the first people outside the home to learn of domestic violence[38]. As discussed under exemptions below, medical evidence may be needed by survivors of domestic violence whose relationship with their British or settled UK spouse or

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[31] Sigona, N., and V. Hughes, *No Way Out, No Way in*, *Irregular migrant children and families in the UK* Compas, 2012, (accessed 22 August 2012) at http://www.compas.ox.ac.uk/fileadmin/files/Publications/Reports/NO_WAY_OUT_NO_WAY_IN_FINAL.pdf

[32] M. Redshaw, R. Rowe, C. Hockley, & P. Brocklehurst, Recorded delivery: a national survey of women's experience of maternity care 2006, National Perinatal Epidemiology Unit.

[33] Doctors of the World, *Access to Health Care for Vulnerable Groups in the EU in 2012*, 2012, page 10.

[34] *The Treatment of Asylum-Seekers,* Tenth report of session 2006-07, HC 60-I and II, HL 81-I and II. Joint Committee on Human Rights, 2007, London, The Stationery Office Maternity Action and Medact (2009); *First do no harm: denying healthcare to people whose asylum claims have failed*, Kelly, N. & J. Stevenson, 2006, London, Oxfam and Refugee Council; *Money and Maternity: charging vulnerable pregnant women for NHS care* UK Public Health Association Conference, Brighton

[35] Lewis, G., J. Drife Why mothers die 2000-2003, *Sixth report of the Confidential Enquiries into Maternal Deaths in the UK London*: Royal College of Obstetricians and Gynaecologists , 2003. See also Centre for Maternal and Child Enquiries, 2011, *Perinatal Mortality 2009: United Kingdom*, London.

[36] Health Inequalities Unit (2007) Department of Health *Review of Health Inequalities Infant Mortality* PSA Target

[37] See the Office for National Statistics Statistical Bulletin: *Focus on violent crime and sexual offences* , 2011/13, England and Wales, 07 February 2013, available at http://www.ons.gov.uk/ons/dcp171778_298904.pdf (accessed 23 August 2013).

[38] See Identifying domestic violence: cross sectional study in primary care, Richardson, J., *BMJ* 2002:324.

sponsor has broken down and who are seeking leave to remain under the domestic violence rule[39].

Religion – members of religious orders that enjoin upon them not to own property and to live a life of poverty will not have paid National Insurance contributions.

Who should be charged?

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

The ordinary residence test has a complex history as it has developed through case law but the meaning now established by the courts gives effect to the policy intentions that shaped the definition and guidance addresses its application in a broad range of circumstances[40]. It is now a bespoke product. The guidance highlights that "The well being of people is paramount in all cases of dispute."

The current definition is not affected by changes in particular immigration categories. Such changes are extremely frequent as an examination of the statements of changes in immigration rules reveals[41]. For example this year there have been statements of changes in January, February, March (twice), April and July. Changes often take place at very short notice because the Home Office is trying to avoid a flurry of people squeezing in "under the wire" between the announcement of a change and a change being made. The Department of Health should think very carefully about whether it could or would want to cope with eligibility being linked to immigration categories. This appears to fail the test imposed by "A system that is workable and efficient".

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) *[same as Home Office question 1]*

No.

Many persons who do not yet have permanent residence are on a route to settlement and will settle in the UK. It is artificial to ignore this. It is not currently a requirement for UK nationals and the settled that they have made sufficient contribution to UK tax and National Insurance before they can access the National Health Service, indeed many people cost the National Health Service more in their early years than they do again until they reach old age.

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[39] Immigration Rules, HC 395, paragraphs 289A to 289C.

[40] See *ORDINARY RESIDENCE: Guidance on the identification of the ordinary residence of people in need of community care services,* Department of Health, April 2013 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/185851/Guidance_on_the_identification_of_the_ordinary_residence_of_people_in_need_of_community_care_services__England_V2.pdf accessed 25 July 2013.

[41] See Statements of Changes in Immigration Rules (accessed 25 July 2013), at http://www.ukba.homeoffice.gov.uk/sitecontent/documents/policyandlaw/statementsofchanges/

However, very many persons who will ultimately settle in the UK spend a very long time in the UK before they do so. Application fees are one reason: while paying for repeat applications for temporary leave could result in spending more than the settlement fee, a person may not have the larger fee at a given time. Some people do not manage to pass the English language test for many years, if at all. Others have criminal convictions. Criminal convictions that are spent are not treated as spent for immigration and nationality purposes[42]. A person sentenced to any period of imprisonment, however short, will have to wait at least seven years to be considered for indefinite leave to remain[43].

Changes to the immigration rules in July 2012[44] result in persons given leave to remain because of the UK's obligations under Article 8 of the European Convention on Human Rights being given limited leave and not being eligible for settlement until they have spent 10 years in the UK with limited leave[45]. In the light of this, it would appear inequitable for the Department of Health to focus on immigration status and leave aside all considerations of length of residence.

It is suggested in the evidence document[46] that permanent residents would be defined as those who have lived in the UK for a minimum of five years or those who have indefinite leave to remain in the UK and we consider that the five year cut-off is a necessary additional restriction in the light of the considerations identified above. See also the answer to question 3 above.

This proposal fails the principles of

- A system that ensures access for all in need
- A system where everybody makes a fair contribution to the NHS (insofar as the principle is comprehensible)
- A system that does not increase inequalities

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?

The way the question is phrased might be read as implying tacit agreement with charges for other groups. We do not agree with charges for those groups.

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[42] UK Borders Act 2007, s 56A, see the Legal Aid Sentencing and Punishment of Offenders Act 2012, ss 140 and 141.

[43] See the Home Office Modernised guidance, General grounds for refusal, About this guidance: reasons for refusal and checks, Criminal history, Sentence thresholds, applications for indefinite leave to remain at http://www.ukba.homeoffice.gov.uk/sitecontent/documents/policyandlaw/modernised/general-grounds-refusing/about.pdf?view=Binary The "Modernised Guidance" is as hard to navigate and understand as it appears at first sight, if not worse.

[44] Statement of Changes in Immigration Rules HC 194.

[45] See e.g. the Immigration Directorate Instructions, Chapter 8, Annex, *Guidance on application of EX.1, Op cit. – consideration of a child's best interests under the family rules and in article 8 claims where the criminality thresholds in paragraph 399 of the rules do NOT apply*, Home Office, at http://www.ukba.homeoffice.gov.uk/sitecontent/documents/policyandlaw/IDIs/chp8-annex/ex1-guidance-1.pdf?view=Binary (accessed 23 August 2013).

[46] *Op. cit.* page 13.

We do agree that those with a long-term relationship with the UK should not be charged. However, many persons with a long-term relationship with the UK cannot evidence this by National Insurance contributions. There are many persons who have been long term residents of the UK but have not paid seven years' National Insurance contributions although they have made other payments, including Value-Added Tax. The basis of calculation is thus inadequate and may also be discriminatory. The reasons for not having paid may include maternity, caring responsibilities, disability or ill-health. The National Health Service is not a contribution-based system. We consider that the proposal does not satisfy the principles of "A system that does not increase inequalities" "A system that ensures access for all in need" and "A system where everybody makes a fair contribution to the NHS".

British citizens resident abroad may return to the UK in stressful circumstances, to care for someone who is ill, or following the death of their own spouse or partner or because their own health has deteriorated and they need family care. They may stand in particular need of health care at this time.

We consider that the proposal does not satisfy the principle "A system that is workable and efficient". There is no straightforward way of distinguishing a person who returns/comes to the UK to take up permanent residence and those who have permanent residence elsewhere and are only in the UK temporarily.

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? [*Equivalent to Home Office question 1]*

The question does not admit of a yes/no answer because it is misconceived. The category of "temporary migrant" is misleading: large numbers of persons with limited leave are on a route to settlement. Such persons, along with other migrants whose stay is temporary, already make such a contribution through the payment of taxes: on income and Value-Added Tax, etc. and payment of National Insurance contributions. Income from taxation in the UK is not hypothecated and in such a context the language of a "direct" or "indirect" contribution is misleading.

The term is also misleading insofar as it suggests someone in the UK for a short period. As descried above, since July 2012[47] it is not uncommon for family migrants to be expected to accrue 10 years of lawful leave before qualifying for settlement[48]. Persons with limited leave cannot settle in less than five years and many take much longer than this to achieve settlement.

We do not support the proposal to charge all those without permanent residence and their dependants for National Health Service care for the reasons given in this

[47] Statement of Changes in Immigration Rules HC 194.

[48] As described in the Immigration Directorate Instructions, Chapter 8, Annex, *Guidance on application of EX.1, Op cit. – consideration of a child's best interests under the family rules and in article 8 claims where the criminality thresholds in paragraph 399 of the rules do NOT apply*, Home Office, at http://www.ukba.homeoffice.gov.uk/sitecontent/documents/policyandlaw/IDIs/chp8-annex/ex1-guidance-1.pdf?view=Binary (accessed 23 August 2013).

response. The principle "A system where everybody makes a fair contribution to the NHS" is opaque, but we do not consider that what is proposed could properly be described as fair.

We strongly suggest that dependants should be left out of the question. No one suggests that British citizen or settled children should make contributions in their own right to the National Health Service or that their parents should pay additional contributions, against the possibility that the children leave the UK or die before they have a chance to contribute in their own right.

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? *[Equivalent to Home Office question 3]*

As set out in the consultation paper, the UK has yet to recoup from other member States of the European Union those costs for which is it entitled to be reimbursed. This should be done. Costs of healthcare should be paid for by general taxation, to which migrants also contribute.

We consider that an insurance option is the worst of the proposals. Insurance policies do not cover everything. In particular, few cover pre-existing conditions and thus the proposal does not meet the condition of not increasing inequalities. Checks that a particular treatment was covered for a particular individual would be difficult to administer. Even where there was agreement that the insurance company should meet the costs of particular National Health Service treatment there are likely to be disputes about the size of the claim and about what is or is not covered. There is no comparison between these policies and holiday health insurance. In the latter case the insurer does not anticipate paying out on the vast majority of claims. The proposal is neither workable nor efficient.

It is open to migrants to have private health insurance just as this is open to British citizens. We anticipate that many of those able to pay for private health insurance would chose to pay any National Health Service levy as well and we can think of few if any circumstances in which we should recommend that those able to do this did not do it.

There should be no question of excluding those who hold such insurance from immediately necessary or urgent treatment. If this cannot be reclaimed from the insurer then the costs should be met as for any other recipient of the care.

If there is a health levy payable prior to arrival then in accordance with the principle of not increasing equalities, consideration should be given to tailoring it, through use of a multiplier such as those used in assessing earnings in the points-based system to ensure it does not present a barrier for those nationals of countries where earnings are low and currencies weak relative to the UK. This is also a reason for not making a person pay the levy for their entire period of leave up front: to do so exacerbates the effect of existing disparities.

Any payment made as part of an application would have to be refunded if that application were unsuccessful.

Travel insurance has a role for holiday makers and visitors as at present as it is likely to cost less than any levy. However, care would have to be taken to ensure that they would still, in accordance with the principle of ensuring access for all in need, be able to access not only immediately necessary treatment but treatment without which their longer term health will be affected.

Many persons in the UK without leave will be unable to pay a levy. They may be persons whose claim for asylum has failed but who cannot be returned to their country of origin because they cannot be documented or because travel to their country is too unsafe to be undertaken, or because of their own general health or circumstances: for example they may be dying and too ill to fly, or they may be unable to fly by reason of pregnancy. They may be overstayers or persons who have so far escaped detection. It is likely that if they face registration and if they face charges for treatment these people will not present for treatment[49]. If they are charged, they will not be able to pay. This is thus a policy question: how does the Department of Health want them to behave?

We know because it is proposed as a principle that the Department wants access for all in need and does not want to increase inequalities. Thus we conclude that the Department wants these people both to present for, and to receive, treatment. This is achieved by not charging them. We recall that in 1999, when the Home Office was setting up the now notorious "National Asylum Support Service" it considered the circumstances of those who presented as destitute but had wealth about their person, for example in the form of a gold wedding ring. It was suggested by the Home Office that a person should sell their wedding ring to be treated as destitute. It was put to the Home Office: what did they want to achieve? What did they want to happen to the person who, although homeless and starving, would not sell their wedding ring?[50] In the end the Home Office opted for according a nominal value to wedding rings, etc. This proved too bureaucratic and the controversial proposals were never enforced.

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)? *[equivalent to Home Office question 4]*

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[49] See *First do no harm: denying healthcare to people whose asylum claims have failed*, Kelly, N. & J. Stevenson, 2006, London, Oxfam and Refugee Council .

50 See Immigration and Asylum Bill, Special Standing Committee Tuesday 11 May 1999 http://www.parliament.the-stationeryoffice.co.uk/pa/cm199899/cmstand/special/st990511/am/90511s09.htm Ms Abbott: *Is the Minister suggesting that asylum seekers should sell their jewellery, perhaps their wedding rings, as an alternative to the Government meeting their moral and international responsibilities to provide a reasonable level of support?* Mr. O'Brien*: I certainly am suggesting that.*—[Interruption – *[recorded in contemporary accounts as a Conservative back bencher saying 'You'll be wanting the gold fillings out of their teeth next' – see for example* D Guttenplan's review of Louise London's book *Whitehall and the Jews 1933-48*, in the London Review of Books, Vol. 22, No. 13 , 6 July 2000 pages 28-29.

c) Other amount.

ILPA does not agree with the imposition of a levy at all.

If a levy is imposed, then it should not be an annual fee. The longer a person stays in the UK, the more tax and national insurance they are paying.

We reproduce the table 3 from the evidence annexe[51]. It is a rough and ready calculation but it does serve to cast doubt on the £200 per year calculation and suggest that this is too high to accord with most notions of fairness. The justification for treating migrants differently from the resident population is stated to be the latter's long term connection with the UK. But if that is correct then over the course of a lifetime the British citizen or settled person will make the greater demands on the National Health Service associated with increasing age. Those migrants who remain in the UK long enough to make these demands will remain in the UK long enough to make contributions akin to those made by a British citizen or settled person. The figures for each age bracket are averages and include persons making very heavy demands on the National Health Service because of disability or chronic conditions. We suggest that such persons are under-represented among 'temporary' migrants and that a consideration of the demographic evidence as to the health of migrants is required. Many migrants faced with, for example, a serious illness or an underlying health problem will chose to return to the country of origin to have it treated (as the consultation paper identifies in Part Six is the case for British citizens). Against the spectre of health tourism, unquantified and ill-defined in the consultation and challenged by other careful studies[52], is the question of the circumstances in which migrants draw less heavily on the National Health Service than they are entitled to do.

Table 3: 2011-12 age- health care costs summary

Common Age Bands	Average HCHS[1] Cost / head 2011-12	Average Prescribing[2] Cost / head 2011-12	Average PMS[3] Cost / head 2011-12	HCHS + Mental Health + Prescribing + PMS £s/head	ONS 2011 Census based population (000s)	2011-12 Spend by Ageband (£000s)
0_4	489	24	210	722	3,329	2,403,519
5_14	457	28	56	540	6,058	3,274,101
15_44	559	66	88	714	21,511	15,348,081
45_64	1,213	193	152	1,558	13,480	21,006,649
65_74	2,993	401	253	3,647	4,592	16,748,065
75+	5,377	517	368	6,261	4,137	25,988,460
Total	**1,295**	**155**	**146**	**1,596**	**53,107**	**84,768,874**

Source: Estimates based on Nuffield G&A and Mental Health age cost indices and scaled to 2011 ONS Census population and spend from the 2011-12 DH Annual Report & Accounts.

[51] *Sustaining services, ensuring fairness: Evidence to support review 2012 policy recommendations and a strategy for the development of an Impact Assessment,* Department of Health, 3 July 2013.
[52] See, e.g. *The Myth of HIV Health Tourism*, National AIDS Trust, 2008.

The Government has long been on notice that it and its predecessors have failed to produce any evidence that would allow the existence of health tourism to be identified or its prevalence to be quantified. As long ago as 2007 the Joint Committee on Human Rights found that

> "*the Government has not produced any evidence to demonstrate the extent of what it describes as 'health tourism' in the UK*" .

Such data as exists points the other way. Doctors of the World UK has collected data from its clinic in East London for seven years. Those using its service had been living in the UK for an average of three years before trying to get healthcare. It identified 1.6% of its service users as having left their country of origin for personal health reasons, a broader definition than that of the health tourist[53]. The National Aids Trust has demonstrated, drawing on research including from the Terrence Higgins Trust and George House Trust, that the available data does not support "the myth of HIV health tourism"[54]. Many persons with HIV wait months or years after coming to the UK before accessing treatment.[55] and many do not do so unprompted, yet such a person is ill-advised to delay treatment for such a long period. Doctors of the World's cross European study covering seven countries and 14 cities found no correlation between accessibility of healthcare and migration patterns[56].

As identified in the evidence document[57] a levy may lead to those who have paid it viewing themselves as having paid for National Health services and thus accessing these more than they would otherwise have done. While the evidence document inclines to conclude that this risk will not materialise, evidence from research should lead to caution[58]. The 2012 review identified that "…exempt visitors tend to use the NHS no more, and usually less, than the resident population. [59]" Those who have paid the levy may be anxious to get their money's worth, rather than, as is often the case at the moment, impressed at, and grateful for, the service they receive and keen to moderate their demands upon it.

The sum at stake, the starting figure in the consultation being £200, appears modest. It is not. Factor in that it is a payment per year, that there will be a levy for each family member and then consider average earnings in different countries and exchange rates with the UK and it will act as a bar to entry for many people. Even without annual or periodic increases.

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[53] Access to healthcare in Europe in times of crisis and rising xenophobia Doctors of the World International Network, 2013 . See also Doctors of the World UK (2013)The importance of equitable access to healthcare for people in England: a policy briefing http://www.appgmigration.org.uk/sites/default/files/Doctors%20of%20the%20World%20-%20access%20policy%20briefing%2009072013.pdf (accessed 23 August 2013).

[54] *The Myth of HIV Health Tourism,* National Aids Trust, October 2008.

[55] Health Protection Agency, *HIV in the United Kingdom*, 2011.

[56] Doctors of the World, *Access to Health Care for Vulnerable Groups in the EU in 2012*, 2012, p. 7-9.

[57] Page 18, disadvantages.

[58] 'A Fine is a Price', Gneezy, U & A Rustichini (2000) *Journal of Legal Studies*, Vol XXIX, January 2000. See 'Zero as a Special Price: The True Value of Free Products' Shampanier, K et ors (2007) *Marketing Science*, Vol 26, No. 6.

[59] *Op.cit.* page 15, paragraph 53.

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?
c) Fixed
d) varied *[Equivalent to Home Office question 6]*

c) Fixed.

Variation based on age risks age discrimination and discrimination on the grounds of a protected characteristic such as maternity. It also opens the door to arguments about the appropriate fee in the particular case.

However, see above, we consider that any levy payable prior to arrival in the UK should be adjusted to take account of strength of currency and earnings in countries a because these will result in certain nationalities being less able than others to come to the UK whatever their earning power once in the UK.

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) [*equivalent to Home Office question 5]*

This question does not admit of a yes or no answer because there is nowhere in it to indicate an objection to the levy.

Were a levy to be imposed, we consider that migrants should be given freedom of choice as to whether to opt for health insurance or for the levy. As set out above, we anticipate that many of those able to pay for private health insurance will chose to pay any National Health Service levy as well and we can think of few, if any, circumstances in which we should recommend that those able to do this did not do it.

A visitor takes out travel insurance hoping that they will not need to avail themselves of health care during their visit. A person who comes to the UK for one or more years anticipates that at some stage during their stay they will need health care. The levy is more likely to ensure that they are covered than is health insurance.

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) *[Equivalent to Home Office question7]*

No.

Many of those successfully applying for an extension of leave are on a route to settlement and are likely to be paying contributions through the tax and national insurance system for the rest of their lives.

As to those already in the UK when the system comes into force, to impose a new levy does not accord with the principle of fairness, because people could not have

factored this in at the time of making a decision to come to the UK. It may result in increased applications for settlement where persons conclude that costs of applying for settlement must now be offset by the costs of the health levy in addition to other fees. We anticipate that the consultation itself, together with the consultation on immigration checks in private rented accommodation, will itself prompt applications for settlement.

Any payment made as part of an application, whether by a person outside the UK or within the UK, would have to be refunded if that application were unsuccessful. Or any levy paid following approval of an application rather than on application.

A significant proportion of temporary migrants in the UK do not have biometric residence documents. The diversity of documents evidencing status in this group adds to the complexity of administering the system. Such diversity is not set immediately significantly to reduce and would present challenges for any system.

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?

No.

The current system of charging for secondary care is not successful in its aims of recouping the costs of treating overseas visitors[60] and we question the extent to which administration of the charges swallows profits. The Department of Health evidence is that hospitals identify some 40% of persons liable to pay charges and recover some £20 million of the £45 million charges levied. Costs of Overseas Visitors Managers and screening by National Health Service staff is estimated at £18 million. Other costs, such as those of debt recovery, translation etc. are not quantified.

Charging for health care can lead to persons not seeking treatment, with risks to public health and also risks of higher costs when their problem develops into a medical emergency. See our response to questions two and seven above.

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?

No.

This has been the cause of appalling suffering and put individuals' health at grave risk[61]. It violates the principle of ensuring access and that of not increasing inequalities. It has public health consequences.

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[60] Department of Health, E*vidence to support review 2012 policy recommendations and a strategy for the development of an Impact Assessment*, July 2013, page 11.

[61] *First do no harm: denying healthcare to people whose asylum claims have failed*, Kelly, N. & J. Stevenson, 2006, London, Oxfam and Refugee Council.

It was stated in the *2012 Review of overseas visitors charging policy*, that the majority of migrants charged by the National Health Service are persons without the required immigration clearance or documentation[62]. They include refused asylum seekers (some, but not all, of whom would benefit from an exemption for those receiving support under section 4 of the Immigration and Asylum Act 1999) and overstayers. Many will be unable to pay the charges for healthcare they receive. Charges levied are likely never to be recouped. See the conclusion in the evidence document accompanying the consultation: debt recovery is difficult and "in most cases the burden falls on the state" [63]. Again, there is a risk that people do not access healthcare until they require a (costly) emergency intervention.

We highlight particular risks to persons unlawfully present who have been trafficked to the UK and have not yet been identified as trafficked. The UK Human Trafficking Centre in its 2012 baseline assessment identified that over half (54%) of all potential victims of trafficking in the UK were not referred for identification by the "competent authority" within the "National Referral Mechanism[64]. In the press release introducing the 18 April 2013 Department of Health guidance on trafficked persons[65] it is acknowledged that

> *In many cases, victims need treatment for health problems so NHS staffs are uniquely placed to spot, treat and support victims of trafficking [66].*

Similarly there is a risk that because families stay away from health professionals, child abuse and child neglect are not identified[67].

See also our responses to questions two and seven.

Question 14: Do you agree with the proposed changes to individual exemptions? Are any further specific exemptions required? *[overlaps with Home Office question 8]*
What services should we charge for?

Exemptions

We agree with all the proposals to retain exemptions.

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[62] *2012 review of overseas visitors charging policy: Summary Report,* International Policy Team, Department of Health, 2013.
[63] Department of Health, *Evidence to support review 2012 policy recommendations and a strategy for the development of an Impact Assessment*, July 2013, page 11.
[64] *A b aseline assessment on the nature and scale of human trafficking in 2011* UK Human Trafficking Centre 2012, Serious and organised crime agency Intelligence Assessment.
[65] See https://www.gov.uk/government/news/help-for-nhs-staff-to-spot-and-support-trafficking-victims (accessed 22 April 2013).
[66] *The* guidance is *Help for NHS staff to spot and support trafficking victims:* Department of Health, 18 April 2013.
[67] *Safeguarding Children Across Services: Messages from research on identifying and responding to child maltreatment,* Davies, C., and H. Ward, H, 2011 available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/184882/DFE-RBX-10-09.pdf (accessed 22 August 2013) and see the Department of Education 's *Working together to safeguard children: A guide to inter-agency working to safeguard and promote the welfare of children* , 2013.

Former UK pensioners and residents: we consider that it would be helpful to verify that the new proposed exemption will cover all those currently exempt. Women may be disadvantaged by not having paid as many National Insurance contributions as men. Similarly, missionaries and members of religious orders may belong to orders where they are not allowed to own property and may therefore not have made National Insurance contributions. We suggest that for the avoidance of doubt provision should be made to passport all those currently benefiting from an exemption into any new system. Provision should also be made to ensure that if it is later discovered that persons not currently benefiting from an exemption, but who are currently entitled to do so, are excluded under the new scheme then changes will be made to it to include them.

We question what is to be gained by removing exemptions such as for overseas visitors employed on UK registered ships and would welcome sight of the full list of these exemptions. Weird and wonderful exemptions tend to have been put in place for a reason, often in response to a specific problem that has arisen or an international obligation. There is a risk of having to reinvent the wheel. We question whether removal of these categories will result in significant savings for the National Health Service.

As to additional exemptions:

All ***children***, not only those in local authority care, should be exempt from charges. So should ***care leavers/former relevant children*** 18-25 years old as defined under leaving care legislation[68].

Persons granted humanitarian protection or discretionary leave to remain should be exempt from charges. Persons with humanitarian protection are unable to return to their country of origin as are many people with discretionary leave whose claims are often founded on human rights.

Those persons whose claims for asylum have failed but who are not, or not yet, in receipt of section 4 support. There are people who remain in the UK after their claims for asylum have failed and all appeal rights have been exhausted, or when they are otherwise at the end of the line, for example because documents cannot be obtained on which they could be removed, because they are stateless, because it is not safe to travel to their country or because they are unable to travel, for example because they are in the advanced stages of pregnancy, or are very ill. Support is provided under section 4 of the Immigration Asylum Act 1999 to those persons in this situation who are destitute. As part of the application it is necessary to evidence that one is unable to leave the UK. Some persons would be eligible for section 4 support because they are destitute but are unable to evidence that they are unable to leave the UK without evidence of their current state of health. They are in a chicken and egg situation: they cannot get health care until they have obtained section 4 support; they cannot demonstrate eligibility for section 4 support without getting health care.

[68] The Children Act 1989 as amended by the Children (Leaving Care) Act 2000.

There are also failed asylum seekers who do not receive section 4 support because they are cared for by families and friends. They may not be destitute but may be very poor. They will not normally be able to evidence that they are unable to return to their country of origin as this is normally determined during the process of applying for section 4 support and not otherwise, save in the extremely rare cases of a prosecution under section 35 of the Asylum and Immigration (Treatment of Claimants, etc.) Act 2004.

Other indigent persons unable to leave the UK - the case below provides an example.

Case of LA

LA, a single man in his 60s, is from the Caribbean. He came to the UK a few years ago to join his partner, but they split up. He is destitute, deaf, mute, illiterate and does not know sign language. A couple of years ago he was unwell and sought GP treatment but was refused registration due to his immigration status (his visa has expired). He has been looked after by a family friend since then, who has fed and accommodated him, but she cannot do so any longer because she is a local authority foster carer and therefore cannot have him living there any longer without his going through Criminal Records Bureau checks, which cost significant sums of money.

He eventually decided voluntarily to return to his country of origin, but before flights could be arranged he fell gravely ill and was hospitalised. He has been diagnosed with inoperable kidney cancer which has spread to the lung, and because of his immigration status he has been denied life-extending chemotherapy unless he pays a deposit of £50,000. He is medically unfit to fly, however, so he cannot leave the UK. He has now spent over a month in hospital at great cost to the National Health Service. The hospital wants to discharge him but he has nowhere to go; his immigration status means he is not entitled to housing or social security. The local authority social services department refuses to assist. Without a General Practitioner he cannot be placed in a hospice due to commissioning/funding arrangements.

Without treatment he will become progressively sicker, and will require emergency intensive care within weeks, which cannot be withheld pending payment and which will cost as much if not more than the chemotherapy. Without treatment he is expected to die within months.

Medical evidence may be needed by ***survivors of domestic violence*** whose relationship with their British or settled UK spouse or sponsor has broken down and are seeking leave to remain under the domestic violence rules[69]. The domestic violence rule in the immigration rules is for those with limited "probationary" leave as a spouse or partner who would thus not be eligible under the proposals. They too should benefit from an exemption and this could be run in conjunction with the Destitute Domestic Violence concession operated by the Home Office[70]. Consideration should also be given to the plight of those who leave their partners because of domestic violence other than in cases where an application can be made

[69] Immigration Rules, HC 395, paragraphs 289A to 289C.
[70] See http://www.ukba.homeoffice.gov.uk/sitecontent/documents/residency/FAQs-DDV-concession.pdf (accessed 23 August 2013).

under the domestic violence rules, for example the spouses and partners of temporary migrants such as workers or refugees.

We also consider that exceptions should be made for ***domestic workers in private households***[71] ***and for private servants in diplomatic households***[72]. These groups are particularly vulnerable to exploitation and may not have the means to pay for health care themselves. In the light of our comments on human trafficking in response to question 13 above, we consider that they should be given access to health care. Domestic workers in private households are now only permitted to be in the UK for six months and therefore there is little time in which to make an intervention and to identify them as trafficked.

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?

We cannot give a yes or no answer to the question as phrased. We agree with the continued right of any person to register for General Practitioner services. This should not be contingent upon their registration recording their chargeable status.

We emphasise once again that very far from all persons whom it is proposed to charge will have biometric residence documents.

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) *[Equivalent to Home Office question 10]*

No.

The consultation paper makes the case for access to General Practitioners very clearly:

> *Immediate access and ongoing doctor/patient relationships provide for effective management of chronic and other existing conditions and prompt diagnosis and treatment of new health problems. This provides obvious health benefits for the patient, potential cost savings for the NHS, and supports population centred public health protection, including preventing the spread of disease.*[73]

The position of the Royal College of General Practitioners is that

[71] Immigration Rules HC 395 paragraphs 159~A to 159H.
[72] Immigration Rules HC 395, paragraphs 152 to 159.
[73] Paragraph 4.13.

> *GPs should not be expected to …turn people away when they are at their most vulnerable. Further, it is important to protect individuals and public health.* [74]

Access to General Practitioners is vital to ensure that diagnosis, including of highly infectious diseases or acute conditions, is made. General Practitioners are central to very many early interventions in individual cases[75] but also to early interventions that may contribute to halting the spread of infectious diseases in the population.

The consultation paper proposes exemptions for infectious diseases and sexually transmitted infections, but it is likely to be at the General Practitioner's surgery that these conditions are diagnosed. The Royal College of General Practitioners' weekly returns are key not only to spotting epidemics and pandemics but to making the appropriate level of provision, avoiding not only spending too little, but spending too much[76].

In 2011 over 60 per cent of African-born men and women were diagnosed with HIV "late", i.e. after treatment should have started.[77] Research suggests that more than half of new HIV infections are passed on by people who are undiagnosed.[78]

We identify a risk of litigation, actions for damages against General Practitioners and/or others who get the decision as to whether a person is eligible for treatment wrong and against General Practitioners who get the decision as to whether a person is in need of immediate necessary or urgent treatment wrong. These actions could be brought by the person wrongly denied care or by others infected by a disease they have transmitted.

The Government is committed to an effective programme of immunisation programme to try to reduce the incidence of childhood infections[79]. The Healthy Child Programme is based in General Practitioners' surgeries[80]. The National Institute for Clinical Excellence has identified:

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[74] Royal College of General Practitioners Position Statement, *Failed asylum seekers/vulnerable migrants and access to primary care*, January 2013.
[75] *Early Intervention: The Next Steps; an Independent Report to Her Majesty's Government* Allen G., The Stationery Office; 2011.
[76] *See The 2009 Influenza Pandemic: an independent review of the UK response to the 2009 influenza pandemic*, Dame Deirdre Hine, July 2010 .
[77] Health Protection Agency, *HIV in the United Kingdom*, 2011.
[78] Hall HI et al. *HIV transmissions from persons with HIV who are aware and unaware of their infection, United States*. AIDS 26, online edition. DOI: 10.1097/QAD013e328351f73f, 2012.
[79] *Improving Children and Young People's Health Outcomes: a system wide response*, Department of Health with the Care Quality Commission, Department for Education, Health Education England, Healthwatch England, Medicines and Healthcare products Regulatory Authority, 33 Monitor, NHS Commissioning Board, NHS Information Centre, NHS Trust Development Authority, National Institute for Health and Clinical Excellence, Public Health England, Royal College of General Practitioners, Royal College of Nursing, Royal College of Paediatrics and Child Health and the Royal College of Psychiatrists, 2013.
[80] Department of Health (2013) *Healthy Child programme: pregnancy and the first five years of life* https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/167998/Health_Child_Programme.pdf (accessed 22 August 2013).

> *…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"*[81]

as being at particular risk of not being immunised and has emphasised the potential attendant effect on herd immunity[82].

In Northern Ireland there is a considerable confusion about migrants' entitlement to free primary health care, stemming from the policy circular Family Health Services for Persons not Ordinarily Resident in Northern Ireland[83] and its relationship to the Provision of Health Services to Persons not Ordinarily Resident Regulations (NI) 2005[84]. Links between this confusion and shortfalls in vaccination resulting in outbreaks of infectious disease have been documented[85].

Self- medication and its link with over medication can be observed in proximity to emergency aid responses and refugee camps all over the world, where medicines from aid agencies make their way into the local markets. People may purchase drugs on the look of the drug alone or in the belief a drug will do things it cannot do – for example an antibiotic treat a virus. When it fails to help, they take more. People who cannot or dare not access the National Health Service will be passed medicines by family and friends. They may take a maximum dose, or more. This may not do them any good, and it may also increase the risk of drug resistant strains developing.

Preventative health care and screening may eliminate the need for more costly treatment at a later stage[86].

There is a risk that charging people to attend General Practitioners' surgeries will displace them on to emergency services[87]. In 2012 the Department of Health found

> *…there is some evidence of higher and sometimes inappropriate use of A&E by short term visitors and others who may experience barriers to registering with a GP.*[88]

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[81] NICE (2009) Reducing differences in the uptake of immunisations (including targeted vaccines) among children and young people aged under 19 years http://www.nice.org.uk/nicemedia/pdf/ph21guidance.pdf

[82] *Ibid.*

[83] HSS (PCD) 10/2000, 23 June 2000.

[84] SRNI 2005/551. See Access to free primary (GP) and secondary (hospital) health care for migrants, Law Centre (NI) Community Care Information Briefing No. 29, July 2013.

[85] Accessing healthcare for migrants in Northern Ireland: problems and solutions, Law Centre (NI) Policy Briefing, 2013 available at : http://www.lawcentreni.org/Publications/Policy-Briefings/Policy-Briefing-Migrants-and-health-care-Law-Centre-NI-2013.pdf (accessed 22 August 2013). This records 15 cases of measles among members of a migrant community in 2012-2013, necessitating hospital treatment in several cases.

[86] Lu, MC et al. Elimination of public funding of prenatal care for undocumented immigrants in California: a cost/benefit analysis. Am J Obstet Gynecol 2000; 182: 233-39.

[87] House of Commons Health Select Committee. NHS Charges: Third Report of Session 2005-2006, HC 815-I, London: The Stationery Office Limited, 2006; Blog, I. Inappropriate attendance at an accident and emergency department by adults registered in local general practices: how is it related to their use of primary care? Journal of health services research & policy 2000; 7 (3): 160. See also Norredam M, Krasnik A, Moller Sorensen T, et al. Emergency room utilization in Copenhagen: a comparison of immigrant groups and Danish-born residents. Scand J Public Health 2004; 32: 53-59.

Attendance at or by emergency services is more costly than attendance at a General Practitioner's surgery[89]. Not having a General Practitioner is also relevant to whether a person can be discharged from hospital, for example where their illness is likely to result in complications or is infectious or both[90].

In 2012 the Department of Health identified that stabilise and discharge systems increase risks around legal duties and do not enjoy the support of clinicians[91].

See also our response to question two above.

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?

Charges should not differ from those imposed on the resident population. The costs of administering charges that differ from those paid by the resident population would appear likely to outweigh the sums recouped.

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

No.

Emergency procedures may be provided to a person who is not conscious, or who is in great pain or great distress. Family members with them may be distraught. Such a person is in no position to consent to receiving treatment for which they will be charged and might afterwards dispute the necessity of the treatment or say that they had consented under duress. The implications for professional ethics of charging are particularly complicated in emergency settings.

The consultation paper sets out (at paragraph 5.21) the intention that treatment in an emergency or for public health need should not be denied. The working assumption in an accident or emergency department must be that the person needs such treatment. A person's presenting at an Accident and Emergency department is an indication that they think that they need such treatment. It may be difficult to communicate with people but given the working assumptions in an Accident and Emergency department if it is not possible to get a clear idea of what a person's concerns are they will be treated as needing emergency treatment.

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[88] Department of Health, *2012 Review of overseas visitors charging policy, Summary report*, April 2012, para.28

[89] Yates, T; Crane, J; Rushby, M. Charging Vulnerable migrants for healthcare. Student British Medical Journal, 2007; 15:427-470

[90] See *Policy briefing: Accessing healthcare for migrant groups*, Law Centre Northern Ireland, June 2013, page 6 a case in which a month's additional hospitalisation resulted.

[91] Department of Health, *2012 Review of overseas visitors charging policy, Summary report*, April 2012, para.62.

There is undoubtedly concern that persons will present at Accident and Emergency departments if they face charges if they go to see their General Practitioner. This is a further reason why people should be able to access General Practitioners: general practice is best able to cope with people who may not need an emergency response, but do require a response.

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

We are unable to identify any workable and efficient system. We consider that the primary concern should be the effect on patient health, and patient suffering rather than "patient flow."

See our response to question 18 above. While there may be patients in Accident and Emergency who are not in such extreme states and who could make an informed decision as to charging, the doctors and nurses have to be allowed to make best use of the time available. Even if an administrative member of staff is dealing with the question of charging, it is going to interfere with the clinical work going on in this highly pressurised environment.

The Health Select Committee's July 2013 report finds that that staffing problems and rising attendances were among the main causes of problems in Accident and Emergency treatment and, with a total 94 out of 148 providers missing the mark, and that the four-hour waiting time target was missed across the National Health Service from January to March 2013[92], against a background of an increase in absolute numbers of people waiting too long. This is in circumstances where a wait could have serious and/or long term consequences for a person's health.

As to staff, members' have expressed astonishment that the very doctors and nurses providing care to others whom they represent could be rendered themselves ineligible to receive care by these proposals.

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

No.

As identified in the consultation paper this would create administrative burdens for charities and others providing these services. It would also create ethical dilemmas such that those best placed to provide these services would be likely to opt out of providing them at all, thus having an adverse effect not only on migrants but on all who had previously received those services. There would be additional costs in monitoring the administration of the system by these providers.

[92] BBC, *A&E crisis plans "not good Enough" MPs say* , 4 July 2013, http://www.bbc.co.uk/news/health-23423796

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

It cannot. See response to question 20. Sums that could be spent treating patients will be spent ensuring that they are not treated. The notion that other healthcare providers could be involved in debt recovery is not workable. They would have no incentive to collect sums from patients or former patients unless a punitive regime were constructed.

Non-National Health Service providers would have to be monitored to ensure that they implemented the charging rules in a non-discriminatory way in line with data protection principles.

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?

Improve systems for recouping payments through existing EEA rules.

Meet service standards and establish baseline data.

Audit compliance with Equality Act 2010 obligations.

Audit compliance with data protection principles. The proposal to link data on health with data on immigration status and data on National Insurance contributions creates a data set more valuable and thus in need of greater protection than data on any of these characteristics separately. Data security would need to be extremely tight.

Identify key indicators where higher than average incidence should always be a bar to the imposition of charges (for example maternal death rates and infant mortality rates) and monitor incidence.

Test for understanding of current entitlements and correct application of correct understanding. Ensure all improvements achieved are sustained over a period of at least two years.

Question 23: How could the outline design proposal be improved? Do you have any alternative ideas?

The "outline design proposal" is not workable. The administrative burden and associated costs appear huge and there is a risk that the harm done to the ethos of the National Health Service will undermine care for all.

We do not identify an alternative proposal for charging that would be workable let alone fair. Not do we identify a proposal which would meet the principles of: a system that ensures access for all in need, a system that is workable and efficient and a system that does not increase inequalities.

We do not identify an alternative proposal for charging that will work within the key constraints identified in the consultation paper (at paragraph 5.21) that treatment in an emergency or for public health need should not be denied, that the needs and interests of the vulnerable or disadvantaged without documentation should be protected, that lawfully resident patients should not be subject to frequent and intrusive checks, that clinicians time should not be devoted (the consultation paper adds the bizarre qualifier "wholesale") from clinical matters, that administrative costs must be minimised and that identification and screening processes must be non-discriminatory.

It is suggested in the evidence paper that entitlement would be recorded on biometric residence documents. Only a proportion of persons who do not have indefinite leave to remain have such documents and a system that relies upon them for record-keeping to be achieved is thus unworkable. The Home Office should be required to provide precise figures on this. These will illustrate the scale of the problem.

As identified in the consultation documents, it is currently unfair that Trusts cannot claim from the National Health Service Commissioners for treatment that they have provided but where they have been unable to recoup the costs. This will continue to be unfair under the proposals because among those on whom charges will be levied will be persons who cannot pay and from whom the Trust has no prospect of reclaiming payment. This carries with it a likelihood of persons being turned away based on an assessment of the likelihood that they will pay any charges levied at some future date, thus undermining the principles of a system that ensures access for all in need and of a system that does not increase inequalities.

It is unfair that Trusts do not receive payment for treatment that they have provided and the proposal in the consultation paper that hospitals and in future others should not be liable for unrecoverable costs of "emergency" treatment should be extended to cover all treatment. It is also not fair that Trusts do not receive payment for treatment that they have provided because this has been spent on debt recovery. However, we question whether removing the liability from Trusts would increase identification as is suggested in the evidence document. They would be in the same position if they failed to identify someone as if they identified them, so the incentive to identify is not large.

As to the statement that "relevant information is accessible from other Government agencies," see our response to question one above. Home Office records are not up to date. Immigration status is a matter of consider complexity and it cannot be assumed that a health professional or subcontractor with access to the Home Office database would be able to determine a person's immigration status from that database, even if that database were up to date which, frequently, it is not. Home Office checking services such as the employers' helpline regularly give out inaccurate information, either because the relevant entry on the database is wrong or because they have not understood it correctly. A person's immigration status may, indeed if they are a "temporary" migrant is likely to, change over time. Those changes are extremely difficult to capture in a system such as the one proposed.

If health records are to draw on Home Office records, they will be infected with the same problems as are Home Office records. The fourth data protection principle requires those making use of personal data to ensure that it is accurate and up-to-date and the Department of Health will thus leave itself open to challenge[93].

In 2012 the Department of Health identified confusion among General Practitioners and primary care trusts as to entitlements to free health care. It described:

> *…a prevailing incorrect belief that a person must be ordinarily resident in the UK in order to qualify for free primary medical services. Some practices have deregistered or failed to register people they believe to be 'ineligible' in some way due to their immigration status. This has resulted in legal challenges from those denied access*"[94]

Save in Northern Ireland[95] it is difficult what might have given rise to such confusion and this is illustrative of the difficulties in training people on a more complex system of entitlements.

A clinic catering for destitute persons seeking asylum in London found that 54% of patients had been turned away, from General Practitioner surgeries. The group included 10 pregnant women. Fifteen persons in the group (some 18%) had one or more serious communicable diseases. Five were HIV positive, six had hepatitis B, two were infectious for hepatitis C and three had tuberculosis.[96] The small size of the sample increases rather than diminishes the concern. A cross-European study by Doctors of the World in 2012 found that in 21% of cases, patients had been denied access to healthcare by a health professional in the preceding 12 months.[97]

The assumption that initial registration could precede registration with a specific practice is not workable. People present when they have a need for health care, if they present at all.

As set out in our response to question one, the proposal is for identity checks in health settings. One cannot have checks for migrants without checking everyone: British citizens and migrants.

Even if a lawful way were found to facilitate data sharing, it would be extremely costly to update patients' records in a timely manner if and when their immigration status changes.

The way in which the Home Office treats migrants can exacerbate the risks to their health. In October 2001 the British Medical Association and the Medical Foundation for the Care of Victims of Torture presented the then government with a dossier called *Asylum Seekers and Health* which included the case of an 18 month-old baby who had never learned to crawl because the accommodation in which the family were housed was so tiny. Persons on asylum support have been dispersed on the

[93] Data Protection Act 1998, Schedule 1.
[94] Department of Health, *2012 Review of overseas visitors charging policy, Summary report,* April 2012, para.2.
[95] Where there exists confusion as described above.
[96] Polly Nyiri, *A specialist clinic for destitute asylum seekers and refugees in London*, BJGP, November 2012.
[97] Doctors of the World, *Access to Health Care for Vulnerable Groups in the EU in 2012*, 2012, p. 7-9.

eve of giving birth[98]. Destitution and homelessness create risks to health. Detainees, including persons whose mental health problems had previously been managed in the prison estate, have seen their mental health deteriorate gravely in immigration detention to the point where the Home Office has, not once but repeatedly, been found to have breached Article 3 of the European Convention on Human Rights (prohibition on torture, inhuman and degrading treatment)[99]. Failure to identify persons who have been subject to torture has resulted in the sequelae of torture not being addressed.

There is a risk that migrants detained under immigration act powers will not be released because they will not receive treatment when released. There could be concerns that, for example, a person with poor mental health will fail to keep in touch with the Home Office because they will not in practice have the medication or other support they require to manage their condition.

Better record keeping by the Home Office and quicker decisions are essential pre-requisites for a workable system. We see no immediate prospect of this. On 28 March 2013, that the Home Secretary abolished the UK Border Agency. She said[100]

> *However, the performance of what remains of UKBA is still not good enough. The agency struggles with the volume of its casework, which has led to historical backlogs running into the hundreds of thousands; the number of illegal immigrants removed does not keep up with the number of people who are here illegally; and while the visa operation is internationally competitive, it could and should get better still. The Select Committee on Home Affairs has published many critical reports about UKBA's performance. As I have said to the House before, the agency has been a troubled organisation since it was formed in 2008, and its performance is not good enough.*
>
> *... I believe that the agency's problems boil down to four main issues: the first is the sheer size of the agency, which means that it has conflicting cultures and all too often focuses on the crisis in hand at the expense of other important work; the second is its lack of transparency and accountability; the third is its inadequate IT systems; and the fourth is the policy and legal framework within which it has to operate. I want to update the House on the ways in which I propose to address each of those difficulties.*
>
> *…the third of the agency's problems is its IT. UKBA's IT systems are often incompatible and are not reliable enough. They require manual data entry instead of automated data collection, and they often involve paper files instead of modem electronic case management.*
> …
>
> *The final problem I raised is the policy and legal framework within which UKBA has operated. The agency is often caught up in a vicious cycle of complex law and poor*

[98] *When maternity doesn't matter: dispersing pregnant women seeking asylum,* January 2013, Refugee Council and Maternity Action.
[99] *R (HA) (Nigeria) v SSHD* [2012] EWHC 979; *R (S) v SSHD* [2011] EWHC 2120 (Admin) (5 August 2011 and *R (D) v SSHD* [2012] EWHC 2501 (Admin); *R (BA) v SSHD* [2011] EWHC 2748 (Admin) (26 October 2011).
[100] Hansard HC Deb 6 Mar 2013 : Column 1500.

enforcement of its own policies, which makes it harder to remove people who are here illegally. …

UKBA has been a troubled organisation for so many years. It has poor IT systems, and it operates within a complicated legal framework that often works against it. All those things mean that it will take many years to clear the backlogs and fix the system, ..."

ILPA considers all the remarks quoted above to be fair and accurate and concurs that it will take many years to clear the backlogs and fix the system. At the moment we experience a demoralised management and workforce floundering.

Simpler rules and clearer immigration categories and procedures would also be required.

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

The principle of access requires that it should be possible to register in the place where the person presents for treatment. This also presents an opportunity to ensure that those with immediate health needs, or who present a threat to public health, are rapidly identified and treated. It may assist in determining the urgency of treatment. A separate registration service might find it easier to live with delays that were causing long term damage or immediate distress to would-be patients.

As per our response to question 23, people are unlikely to present until they need treatment and then are likely to present where they can receive treatment. At that stage they may have a need for emergency treatment and at the very least it will be necessary to establish whether they have such a need. It is not possible to set up a system that does not involve the exercise of clinical judgement by medical professionals. If a person is eligible to pay but must nonetheless be treated in an emergency then it is a matter of clinical judgement to determine whether one is dealing with an emergency. The diagnosis of meningitis in a child is one stark example.

All National Health Service patients should be registered with a General Practitioner and it is ideal that registration is with such a practitioner first. However, this cannot be rigidly enforced because of those whose first presentation to the health services is in an emergency.

Wherever initial registration is located, there will be persons without leave who do not present for treatment because of fears of charges, or fears of being detained and removed. There will also be migrants who for whatever reason are not able to register or who, having registered cannot afford or obtain treatment. In our experience some of these migrants will present multiple times in multiple health care settings: different General Practitioner's surgeries, different Accident and Emergency

departments[101], community health services, emergency support provided by local authorities etc. seeking help. Not only is this a highly inefficient system, it can put patients at risk. We see clients with large numbers of prescription medicines about which they understand little and in a number of cases an expert, for example a doctor writing a medical report, has identified that the particular cocktail of medicines is at best unhealthy, at worst that the medicines are cancelling out each other's effects or exacerbating these in a harmful way.

We oppose subcontracting registration. There are very few companies that would be able to undertake an operation on this scale: Capita? G4S? Serco? Because of the small number of companies likely to be bidding for any contracts, Government negotiators will be in a very weak position to negotiate a good arrangement. All the more so when any contract comes up for renewal. Our experience of Home Office contracts with these companies (Capita for trying to persuade people to leave the UK, G4S and Serco for the COMPAS support contracts) is that officials find it very difficult to manage these contracts effectively. Just as poor management of support contracts places a burden on local authorities so poor management of any registration contract would place a burden on front-line National Health Service staff.

The time and resources spent not treating patients and ensuring that that they are not treated will outweigh the time and resources that would have been better spent treating them.

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?

We are unclear whether this is a question about migrants or about British citizens and the settled as well because we are unclear what is meant by "who need to pay in future." We have set out the challenges in our responses to this paper *passim*: that people do not receive the treatment they need and suffer. That public health suffers. That British citizens and the settled, in particular those from ethnic minorities and those who for different reasons do not possess, or find it difficult to retrieve and present, documentation face discrimination. That a cumbersome and costly bureaucracy develops.

See also our responses to questions two and 16.

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?

[101] See Catherine O'Donnell et ors letter to *The Lancet*, Vol 382, August 3, 2013; Rechel, B., et ors, *Migration and health in an increasingly diverse Europe*, Health in Europe 5; *The Lancet*, Vol 381, April 6, 2013, page 1240 and Royo-Bordonada, M.A. et ors, letter to *The Lancet*, Vol 382, August 3, 2013 .

The statutory gateway for the disclosure of information in a medical context is very strict, even if the information being shared is not medical. To disclose that a person is a patient is itself a matter that goes to medical confidentiality. There is on-going litigation on the sharing of data between hospitals and the Home Office.

As set out in our response to this consultation we are concerned that enormous problems are created if data shared is not accurate and up to date, and Home Office data is not accurate and up to date.

Fears about data sharing are another barrier to persons under immigration control, in particular those without lawful leave, accessing health care. The fear will be that if you seek medical treatment, information will be passed to the Home Office who will arrest you at the place of registration, GP's surgery or hospital. This fear is likely to lead to people not seeking health care for themselves or their children, with the attendant risks to their own and to public health.

The essential safeguard in all data sharing is respect for the principle of informed consent. Data should not be shared without informed consent having been obtained. Informed consent is not obtained through use of some of the general disclaimers all too frequently used on Home Office forms. Rarely if ever do persons understand that these mean information about them can be shared, or how widely. They are all too often all but incomprehensible.

For example, the Home Office uses general blanket waivers on, for example, children's Statement of Evidence forms and interview records:

> *The information you give us will be treated in confidence and the details of your claim for asylum will not be disclosed to the authorities of your own country. However, information may be disclosed to other UK government departments, agencies, local authorities, international organisations and other bodies where necessary for immigration and nationality purposes or to enable them to carry out their functions.*
>
> *Information may be disclosed in confidence to the asylum authorities of other countries which may have responsibility for considering your claim.*

We do not consider that informed consent to sharing with any particular Government agency can be said to have been given by a child confronted with such a waiver. It is impossible to ascertain what might be shared with whom for what purposes. No child can
possibly understand all the functions of all these bodies.

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

No.

These steps may deny British citizens who migrate the benefits of migration. Analysis of multiple data source indicates that more UK residents travel abroad for treatment

than persons come to the UK for treatment[102]. The Government is committed to reducing net migration. Achievement of this goal involves supporting emigration. The sums involved are not large and the principle behind the S1, of allowing early retirees to integrate in their new country of residence, is sound.

As to co-payment, it is suggested that patients might seek fully reimbursed treatment in other Member State to avoid any charges that might apply in the UK. However, no evidence is provided as to whether this is happening at all and if so the scale of it and what proportion of the three million pounds of expenditure it represents.

What proportion of the three million pounds is treatment for which, if persons could not obtain overseas without making a co-payment, they would return to the UK? There is no saving to be made in these cases. The UK operates a system of free healthcare for its citizens and should be proud to export that protection.

Endnote

The lady in the case cited as an example in won her case. She is still alive.

> "*…no society can legitimately call itself civilized if a sick person is denied medical aid because of lack of means.*" Aneurin Bevan [103]

Adrian Berry
Chair
ILPA

28 August 2013

[102] *The UK is a net exporter of patients*, BMJ 2013:346:f669
[103] *In Place of Fear*, Bevan, A., 1952, chapter 5.