ILPA response to the Home Office consultation Controlling Immigration – Regulating Migrant Access to Health Services in the UK

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 Department of Health 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…

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

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

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 it was wrong to accuse the appellant of health tourism. The evidence showed that the Home Office was wrong to resist the conclusion that were the appellant returned to Nigeria she would die within weeks from kidney failure.. 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. It was 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 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 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.

[3] See endnote.

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 to the Department of Health we are unpersuaded that the proposals will save money.

1. Should all temporary migrants, and any dependants who accompany them, make a direct contribution to the costs of their healthcare? (Yes / No / Don't know) [*Equivalent to Department of Health Question 6]*

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. Since July 2012[4] it is not uncommon for family migrants to be expected to accrue 10 years of lawful leave before qualifying for settlement[5]. 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 response and our response to the Department of Health consultation[6].

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.

The proposal is not that migrants should pay an additional sum for their health care but 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[7].

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

[5] 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).

[6] *Sustaining services, ensuring fairness: A consultation on migrant access and their financial contribution to NHS provision in England*, Department of Health, July 2013.

[7] *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[8].

2. 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) [*Equivalent to Department of Health Question 4]*

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.

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[9]. 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[10].

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[8] *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.

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

[10] 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

Changes to the immigration rules in July 2012[11] 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[12]. In the light of this, it would appear inequitable to focus on immigration status and leave aside all considerations of length of residence.

It is suggested in the Department of Health evidence document[13] 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.

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[14]. 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[15]. 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. A system where eligibility was linked to immigration categories would not be workable or efficient.

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

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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.

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

[12] 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).

[13] *Evidence to support review: policy recommendations and a strategy for the development of an Impact Assessment*, Department of Health, July 2013, page 13.

[14] 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.

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

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…"*[16]

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

> *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.* [17]
>
> …
>
> *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.*[18]

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. 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.

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[16] *In Place of Fear*, Bevan, A., (1952), chapter 5.
[17] HC report 9 Jun 2010: Column 345.
[18] *Op. cit.* Col 350.

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.

National Health Service funding was not founded upon a model based on an established, permanently resident population. Aneurin Bevan made this 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…*[19]

3. What would be the most effective means of ensuring temporary migrants make a financial contribution to public health services?

> **a) A health levy paid as part of the entry clearance process**
> **b) Health insurance**
> **c) Other option (please detail your proposals)** [*Equivalent to Department of Health Question 7]*

c) Other option.

They already do make a contribution, see our response to question 1 above.

As set out in the Department of Health consultation paper[20] 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.

[19] *In Place of Fear*, Bevan, A (1952), chapter 5.
[20] *Op.cit.*

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. 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 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[21]. If they are charged, they will not be able to pay.

We know because it is proposed as a principle in the Department of Health consultation that the Department of Health wants access for all in need and does not

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

want to increase inequalities. Thus we conclude that the Department of Health 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 it want to achieve? What did it want to happen to the person who, although homeless and starving, would not sell their wedding ring?[22] 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.

The Health and Social Care Act 2012 placed duties upon the Secretary of State[23] and on Clinical Commissioning Groups[24] to go beyond not increasing health inequalities and to reduce health inequalities[25] . These obligations are not currently being met[26].

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 working from the Home Office database which both reflects the complexity of current immigration law and is not up to date[27]. 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. 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.

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22 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.

23 National Health Service Act 2006, s 1C.

24 National Health Service Act 2006, s 14T.

25 Health and Social Care Act 2012, section 62(4); National Health Service Act 2006, s 1C, 13G and 14T.

26 See, for example, *Growing up in the UK – Ensuring a healthy future for our children*, British Medical Association (2013).

27 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.***

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 both the Home Office and the Department of Health will thus leave themselves open to challenge[28].

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[29] "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[30].

Both the Capita exercise and the campaign involving the vans have been of questionable legality and the subject of considerable controversy[31]. 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 persons under immigration control or British citizens, vulnerable to abuse and victimisation.

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[32]

> *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*

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[28] Data Protection Act 1998, Schedule 1.

[29] 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.

[30] *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.

[31] 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).

[32] Hansard HC Deb 6 Mar 2013 : Column 1500.

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 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.

Addressing health inequalities can bring "real economic benefits and savings[33]. 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*[34]

Such cost benefit analysis as has been carried out does not appear to support charging. The Department of Health evidence paper[35] says that the effect of the charges deterring persons from coming to the UK is unlikely to exceed 0.5% of

[33] *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

[34] 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.

[35] *Op.cit.*

Gross Domestic Product in a given year.[36] But 0.5% of Gross Domestic Product in 2012 was eight billion pounds.[37] 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 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 Department of Health consultation paper suggests that the extent of the complexity of verifying entitlement has been adequately communicated or understood. The Home Office should provide precise figures on the number of valid biometric residence permits in circulation and the proportion of people who are not British citizens or settled who hold one.

4. If a health levy were established, at what level should it be set?
a) £200 per year
b) £500 per year
c) Other amount (please specify) [*Equivalent to Department of Health Question 8]*

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 Department of Health's annexe of evidence[38]. 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,

[36] Department of Health, *Evidence to support review 2012 policy recommendations and a strategy for the development of an Impact Assessment*, July 2013, page 20.
[37] Gross Domestic Product for 2012 was £1,623.48 billion.
[38] *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.

unquantified and ill-defined in the consultation and challenged by other careful studies[39], is the question of the circumstances in which migrants draw less heavily on the National Health Service than they are entitled to do.

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[40]. 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"[41]. Many persons with HIV wait months or years after coming to the UK before accessing treatment[42] 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[43].

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	388	6,281	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.

[39] See, e.g. *The Myth of HIV Health Tourism*, National AIDS Trust, 2008.
[40] *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).
[41] *The Myth of HIV Health Tourism,* National Aids Trust, October 2008.
[42] Health Protection Agency, *HIV in the United Kingdom*, 2011.
[43] Doctors of the World, *Access to Health Care for Vulnerable Groups in the EU in 2012*, 2012, p. 7-9.

As identified in the Department of Health evidence document[44] 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[45]. The 2012 review identified that "…exempt visitors tend to use the NHS no more, and usually less, than the resident population. [46]" 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.

5. Should some or all categories of migrant be granted the flexibility to opt out of paying a migrant health levy, for example where they hold medical insurance for privately provided healthcare? (Yes, some categories / Yes, all categories / No / Don't know) [*Equivalent to Department of Health Question 10]*

If you responded with 'Yes, some categories', please specify.

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.

6. Should a migrant health levy be set at a fixed level for all temporary migrants, or varied (for example according to the age of the migrant)?

a) Fixed level

b) Varied level

c) Don't know [*Equivalent to Department of Health Question 9]*

[44] Page 18, disadvantages.

[45] '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.

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

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.

7. Should temporary migrants already in the UK be required to pay a health levy as part of any application to extend their leave? (Yes / No / Don't know) [*Equivalent to Department of Health Question 7]*

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.

8. Are there any categories of migrant that you believe should be exempt from paying the health levy or other methods of charging (over and above those already exempt on humanitarian grounds or as a result of our international obligations)? (Yes / No / Don't know). If yes, please specify. [*Equivalent to Department of Health Question 14]*

Yes.

We agree with all the proposals to retain exemptions set out in the Department of Health consultation paper[47]. Those include former UK pensioners and residents and 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 the proposals set out in the Department of health consultation to remove 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[48].

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.

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[47] *Op.cit.*

[48] 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[49]. 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[50].

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

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 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***[51] ***and for private servants in diplomatic households***[52]. These groups are particularly vulnerable to exploitation and may not have the means to pay for health care themselves. 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.

9. Should any requirement to hold health insurance be a mandatory condition of entry to the UK (as determined by the Home Office)? (Yes / No / Don't know) ***[No equivalent in Department of Health consultation]***

No.

ILPA does not support the imposition of charges for the reasons set out in this response and in response to the Department of Health.

10. Should chargeable migrants pay for all healthcare services, including primary medical care provided by GPs? (Yes / No / Don't know) [*Equivalent to Department of Health Question 16]*

No.

The Department of Health 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.*[53]

The position of the Royal College of General Practitioners is that

> *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.* [54]

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

[51] Immigration Rules HC 395 paragraphs 159~A to 159H.
[52] Immigration Rules HC 395, paragraphs 152 to 159.
[53] Paragraph 4.13.
[54] Royal College of General Practitioners Position Statement, *Failed asylum seekers/vulnerable migrants and access to primary care*, January 2013.

very many early interventions in individual cases[55] but also to early interventions that may contribute to halting the spread of infectious diseases in the population.

The Department of Health 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[56].

In 2011 over 60 per cent of African-born men and women were diagnosed with HIV "late", i.e. after treatment should have started.[57] Research suggests that more than half of new HIV infections are passed on by people who are undiagnosed.[58]

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[59]. The Healthy Child Programme is based in General Practitioners' surgeries[60]. The National Institute for Clinical Excellence has identified:

> *…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*"[61]

as being at particular risk of not being immunised and has emphasised the potential attendant effect on herd immunity[62].

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[55] *Early Intervention: The Next Steps; an Independent Report to Her Majesty's Government* Allen G., The Stationery Office; 2011.
[56] *See The 2009 Influenza Pandemic: an independent review of the UK response to the 2009 influenza pandemic*, Dame Deirdre Hine, July 2010 .
[57] Health Protection Agency, *HIV in the United Kingdom*, 2011.
[58] 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.
[59] *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.
[60] 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).
[61] 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
[62] *Ibid.*

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[63] and its relationship to the Provision of Health Services to Persons not Ordinarily Resident Regulations (NI) 2005[64]. Links between this confusion and shortfalls in vaccination resulting in outbreaks of infectious disease have been documented[65].

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.

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*"[66]

Save in Northern Ireland[67] 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.[68] 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.[69]

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[63] HSS (PCD) 10/2000, 23 June 2000.
[64] 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.
[65] 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.
[66] Department of Health, *2012 Review of overseas visitors charging policy, Summary report,* April 2012, para.2.
[67] Where there exists confusion as described above.
[68] Polly Nyiri, *A specialist clinic for destitute asylum seekers and refugees in London*, BJGP, November 2012.
[69] Doctors of the World, *Access to Health Care for Vulnerable Groups in the EU in 2012*, 2012, p. 7-9.

Preventative health care and screening may eliminate the need for more costly treatment at a later stage[70].

There is a risk that charging people to attend General Practitioners' surgeries will displace them on to emergency services[71]. 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.*[72]

Attendance at or by emergency services is more costly than attendance at a General Practitioner's surgery[73]. 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[74].

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[75]. In the press release introducing the 18 April 2013 Department of Health guidance on trafficked persons[76] 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* [77].

Similarly there is a risk that because families stay away from health professionals, child abuse and child neglect are not identified[78].

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[70] 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.

[71] 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.

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

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

[74] 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.

[75] *A baseline assessment on the nature and scale of human trafficking in 2011* UK Human Trafficking Centre 2012, Serious and organised crime agency Intelligence Assessment.

[76] See https://www.gov.uk/government/news/help-for-nhs-staff-to-spot-and-support-trafficking-victims (accessed 22 April 2013).

[77] *The* guidance is *Help for NHS staff to spot and support trafficking victims:* Department of Health, 18 April 2013.

[78] *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.

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[79].

The Secretary of State for Health and clinical commissioning groups are under a duty is to reduce inequalities[80].

The proposals may affect people with characteristics protected under the Equality Act 2010 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[81]. 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 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[82]. This is in line with the experiences of ILPA members working with poor migrants.

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.

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[83]. See also the response to question 22 below.

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.

Research has identified that some 83% of women first seek maternity care through their General Practitioner[84]. In their cross-European study, Doctors of the World

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[79] Department of Health, *2012 Review of overseas visitors charging policy, Summary report*, April 2012, para.62.
[80] Health and Social Care Act 2012, s 62(4); National Health Service Act 2006, s 1C, 13G and 14T.
[81] See *First do no harm: denying healthcare to people whose asylum claims have failed*, Kelly, N. & J. Stevenson, 2006, London, Oxfam and Refugee Council .
[82] 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).
[83] 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.
[84] 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.

found that on average 79% of respondents were not accessing antenatal care[85]. 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[86]. 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[87]. There are also risks to the health of the child, and of increased infant mortality[88].

Women will be disproportionately affected by the pregnancy and maternity provisions.

Doctors may be the first people outside the home to learn of domestic violence[89]. 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 who are seeking leave to remain under the domestic violence rule[90].

Endnote

The lady in the case cited as an example 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[91]

Adrian Berry
Chair
ILPA
28 August 2013

[85] Doctors of the World, *Access to Health Care for Vulnerable Groups in the EU in 2012*, 2012, page 10.
[86] *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
[87] 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.
[88] Health Inequalities Unit (2007) Department of Health *Review of Health Inequalities Infant Mortality* PSA Target.
[89] See Identifying domestic violence: cross sectional study in primary care, Richardson, J., *BMJ* 2002:324.
[90] Immigration Rules, HC 395, paragraphs 289A to 289C.
[91] *In Place of Fear*, Bevan, A., 1952, chapter 5.