IMMIGRATION BILL
ILPA BRIEFING FOR HOUSE OF COMMONS COMMITTEE STAGE

PART III Chapter 11 Health General Briefing

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INTRODUCTION

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…"*[1]

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.* [2]
>
> …
>
> *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*
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> > *"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.*[3]

It is not the mere fact of a card that produces discomfort or that those carrying out the checks are remote emanations of the State: private citizens checking upon each other. British citizens, EEA nationals and third country nationals alike would be

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

required to produce identity documents at many turns in schemes that would be intrusive, bullying, ineffective and expensive and likely racist and unlawful to boot .

The consultation paper is wrong in suggesting[4] 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…*[5]

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 that accompanied the Department of health consultation[6]. 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.

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.

These provisions must be read with the provisions of Clause 1 and the loss of appeal rights in Clause 3. A wrongful refusal by the Secretary of State could jeopardise a person's access to health care. Health care could be denied while the person pursued a judicial review against the wrongful decision. This may lead to people pursuing an administrative review or human rights appeal in parallel with a judicial review, simply to preserve their entitlements during the period of challenge, increasing the work that must go into resolving the challenge. The consequences of refusal will increase pressure on courts and tribunals to conclude judicial reviews rapidly.

The Bill contains only enabling provisions on limiting migrants' access to the National Health Service and the Government's response to the consultations on the National Health Service has yet to be published. ILPA responded to both the Department of Health and the Home Office consultations[7]. We argued against this extension of identity checks to the population as a whole.

What we see on the face of the Bill are proposals to confine entitlement to the National Health Service to British citizens and settled persons (clause 34) with the entitlements of others to be controlled by regulations (clause 33). Some of those not automatically entitled

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[4] Paragraph 2.10.
[5] *In Place of Fear*, Bevan, A (1952), chapter 5.
[6] *Op.cit* page 9.
[7] ILPA's response to the Department of Health consultation is available at http://www.ilpa.org.uk/resources.php/20831/ilpa-response-to-the-department-of-health-consultation-sustaining-services-ensuring-fairness-a-consu

will be able to secure entitlement to all or some services, as determined by the Secretary of State, by paying a levy.

The suffering of individuals and the risks to public health militate against the proposal. Checks risk preventing or deterring persons, including British citizens, who cannot prove their status at the time when this is needed from accessing health services for themselves and their children.

CLAUSE 33 STAND PART

Clause 33 empowers the Secretary of State to impose a levy on all or some persons making an application to come to the UK from overseas or to remain in the UK. The Secretary of the State has the power to impose a charge on anyone with limited leave.

The proposal is not that migrants should pay an additional sum for their health care. 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[8].

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, the obese, smokers, those having children, or those with chronic conditions.

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 that accompanied the Department of Health consultant, 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[9].

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[10]. The Government has long been on notice of the need to

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[8] *Review of overseas visitors charging policy, Summary report*, Department of Health, April 2012, paragraph 7.

[9] *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.

[10] *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

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*[11]

Such cost benefit analysis as has been carried out does not appear to support charging. The evidence paper that accompanies the Department of Health consultation 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.[12] But 0.5% of Gross Domestic Product in 2012 was eight billion pounds.[13] 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 reproduce the table 3 from the Department of Health evidence annexe[14]. 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 Department of health consultation paper identified 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[15], 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

[11] 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.
[12] Department of Health, *Evidence to support review 2012 policy recommendations and a strategy for the development of an Impact Assessment*, July 2013, page 20.
[13] Gross Domestic Product for 2012 was £1,623.48 billion.
[14] *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.
[15] See, e.g. *The Myth of HIV Health Tourism*, National AIDS Trust, 2008.

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	366	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.

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*" .

As identified in the Department of health evidence document[16] 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[17]. The 2012 review identified that "…exempt visitors tend to use the NHS no more, and usually less, than the resident population. [18]" 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.

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.

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

[16] Page 18, disadvantages.
[17] '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.
[18] *Op.cit.* page 15, paragraph 53.

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[19]. 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[20].

Changes to the immigration rules in July 2012[21] 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[22]. In the light of this, it would appear inequitable to focus on immigration status and leave aside all considerations of length of residence.

It was suggested in the Department of Health evidence document[23] 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 a cut-off is a necessary additional restriction in the light of the considerations identified above.

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.

If there is a health levy payable prior to arrival 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

[19] UK Borders Act 2007, s 56A, see the Legal Aid Sentencing and Punishment of Offenders Act 2012, ss 140 and 141.
[20] 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.
[21] Statement of Changes in Immigration Rules HC 194.
[22] 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).
[23] *Op. cit.* page 13.

front: to do so exacerbates the effect of existing disparities. A person coming to work in the UK even from a poor country may see their earnings increase rapidly after arrival.

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

Pregnancy

It was 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[24]. Research has identified that some 83% of women first seek maternity care through their General Practitioner[25]. In their cross-European study, Doctors of the World found that on average 79% of respondents were not accessing antenatal care[26]. 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[27]. 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[28]. There are also risks to the health of the child, and of increased infant mortality[29].

Domestic violence

Women are more likely to be victims of domestic violence than men[30] 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[31]. Medical evidence may be needed by survivors of domestic violence whose

[24] 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

[25] 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.

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

[27] *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

[28] 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.

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

[30] 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).

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

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[32].

CLAUSE 34 STAND PART

Clause 34

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**

[…][33]… 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 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"[34]*

[32] Immigration Rules, HC 395, paragraphs 289A to 289C.
[33] We have omitted the name in this public submission.
[34] See endnote.

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.

The Health and Social Care Act 2012 placed duties upon the Secretary of State[35] and on Clinical Commissioning Groups[36] to go beyond not increasing health inequalities and to reduce health inequalities[37] . These obligations are not currently being met[38].

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 information from the Home Office database which both reflects the complexity of current immigration law and is not up to date[39].

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

In recent months we have seen the Home Office launch a campaign with advertisements on vans in particular London boroughs saying that there are 106[40] "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[41].

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[35] National Health Service Act 2006, s 1C.
[36] National Health Service Act 2006, s 14T.
[37] Health and Social Care Act 2012, section 62(4); National Health Service Act 2006, s 1C, 13G and 14T.
[38] See, for example, *Growing up in the UK – Ensuring a healthy future for our children*, British Medical Association (2013).
[39] 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.***
[40] 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.
[41] *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.

Both the Capita exercise and the campaign involving the vans have been of questionable legality and the subject of considerable controversy[42]. 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.

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[43]. 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[44].

Many persons in the UK without leave will be unable to pay. 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

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[42] 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).

[43] 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).

[44] 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.

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[45]. 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 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?[46] 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 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[47]. 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[48]. 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.

Trafficking

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

46 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.

[47] 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.

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

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[49]. 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" [50]. 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[51]. In the press release introducing the 18 April 2013 Department of Health guidance on trafficked persons[52] 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 [53].*

Similarly there is a risk that because families stay away from health professionals, child abuse and child neglect are not identified[54].

Other groups at risk

Children and care leavers/former relevant children 18-25 years old as defined under leaving care legislation[55].

Persons granted humanitarian protection or discretionary leave to remain. 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.

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[49] *2012 review of overseas visitors charging policy: Summary Report,* International Policy Team, Department of Health, 2013.
[50] Department of Health, *Evidence to support review 2012 policy recommendations and a strategy for the development of an Impact Assessment*, July 2013, page 11.
[51] *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.
[52] See https://www.gov.uk/government/news/help-for-nhs-staff-to-spot-and-support-trafficking-victims (accessed 22 April 2013).
[53] *The* guidance is *Help for NHS staff to spot and support trafficking victims:* Department of Health, 18 April 2013.
[54] *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.
[55] The Children Act 1989 as amended by the Children (Leaving Care) Act 2000.

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 if they cannot get health care until they have obtained section 4 support; they cannot demonstrate eligibility for section 4 support without getting health care.