Sustaining services, ensuring fairness

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

Overarching principles

Response to the Consultation on access to healthcare for migrants

Coalition of Latin Americans in the UK (CLAUK)

CLAUK is a coalition of Latin American organisations from the voluntary sector, providing services and advocating for the rights of Latin Americans in the UK.

Our mission is “to raise awareness and understanding of the issues facing the Latin American community in the UK and to provide a collective voice for, and represent the collective interests of the Latin American community in the UK”.

We focus our work on three priorities: gaining official recognition of Latin Americans as an ethnic minority; improving Latin Americans access to health services; and improving Latin Americans access to labour rights.

CLAUK’s current member organisations are:

- The Latin American School of Artistic and Cultural Education (ESFORAL)
- Ecuadorian Movement
- Indoamerican Migrant and Refugee Organisation (IRMO)
- Latin American House
- Latin American Disabled People’s Project
- Latin American Women’s Aid (LAWA)
- Latin American Women’s Rights Service (LAWRS)
- Latin Support Group
- Naz Latina
- Teléfono de la Esperanza
- The National Secretariat for Migrants from the Ecuadorian Government (SENAMI, Observer)

For more information, please visit www.clauk.org.uk

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

Response:

We welcome some of the inclusions in the list of overarching principles, but some very important guiding principles are missing. These include:

- Human Rights, including the right to life, health and a family life.
- Ethical obligations on doctors to provide care to people who are in need, including the Hippocratic Oath.
- Public health and the role of the NHS in improving the health of populations and preventing people from becoming ill (including testing and treating infectious diseases and providing immunisation programmes).
- Existing services standards and guidelines (e.g. NICE guidance) which must not be undermined by restrictions on healthcare access.

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

Response:

There is already extensive evidence that current charging policies have a disproportionate impact on vulnerable groups, including destitute asylum seekers and other undocumented migrants who have no resource to public funds, and this will only increase as further barriers are created to healthcare access.

Under the Health and Social Care Act 2012 the Secretary of State, NHS England and Clinical Commissioning Groups have a responsibility to reduce inequalities by improving the health outcomes of marginalised and vulnerable groups (amongst others). The proposals will not have this impact – instead these inequalities are likely to be increased.

Specific impacts on protected groups will include:

Black and minority ethnic people and people from specific nationalities – As these proposals target non-EEA nationals, BME people and some nationality groups are much more likely to be expected to pay for their healthcare access. In addition, BME people who are EEA nationals are more likely than their white counterparts to have their entitlement questioned by those administering the system. The proposed changes will make it more likely for Latin Americans to face discrimination based on physical features and language.

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

In addition, for migrant communities that come from non-English speaking countries or from countries where the health system does not require registering with a doctor prior to the first appointment, the proposed changes will represent an additional access barrier. Such is the case of Latin Americans, who come from Spanish or Portuguese speaking countries. Although the vast majority of Latin Americans either have citizenship status (EU or UK nationality), or are in the path to citizenship; 1 out of 5 Latin Americans are not registered with the GP due to the language barrier and lack of access to information in their languages (No Longer Invisible, 2011). In addition, many are not familiar with the requirement of registering with the GP before needing assistance. The proposed changes will further raise the barriers many Latin Americans' face in their access to health services.

Women – These changes will disproportionally affect women, as statistics shows that migrant women are more likely to be dependent on male partners. Additionally, women are less likely than men to have accumulated seven years of NI contributions during the same period of residence in the UK as women are more likely than men to take breaks from work to care for children and others. This will worsen their situation and access to entitlements. The proposed changes will represent a new obstacle for women on spouse or dependant visas who are victims of domestic violence, as they will meet a new barrier to disclose their situation to GPs. The provision will be highly discriminatory not to provide services to survivors of violence for free.

Maternity – The consultation specifically targets maternity services for additional charges, even when non-EEA migrants have paid the levy. The proposal to charge for maternity services for 'pre-existing' pregnancies is unworkable and discriminatory. This is a double discrimination on women.

Disability – As the proposals will require a new group of migrants to directly contribute to the costs of their healthcare, those who are living with a pre-existing disability of health condition are clearly going to be more affected. The proposals to require non-EEA migrants who have paid the levy to make an additional contribution for specific services could easily lead to discrimination against people with disabilities requiring specialist and expensive treatment.

Age (children) - Children are also vulnerable to losing their healthcare entitlements following domestic abuse and/or family breakdown. Children also have a range of age-specific health needs which are met by primary care (the Healthy Child Programme). They are also particularly affected by infectious diseases and public health concerns. Children of migrants who are born in the UK will also experience follow-on effects from any restriction on maternity services, which are vital to their healthy start in life. This is not giving them a fair start.

Who should be charged?

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

The current understanding of 'ordinary residence' is a useful concept and should not be replaced.
It is useful concept as it captures the key point which should be considered when establishing eligibility for NHS services: the 'settled' nature of someone's life in the UK. As a broad definition which does not attempt to link eligibility to specific immigration or residency status, it avoids the risk of excluding certain groups which by any reasonable measure should expect healthcare entitlement (for example, people granted humanitarian protection).

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

(Yes / No / Don't know)

Response:

No.

Linking NHS entitlement to permanent residence does not reflect either the commitment or contribution of the migrants who will be affected by these proposals. Although most immigration routes leading to settlement should render migrants eligible for permanent residence after five years, additional requirements to apply for ILR (such as the Life in the UK Test or the minimum income requirement for partners) means that in practice many migrants take much longer to acquire permanent residence. This is particularly the case for older and disabled migrants and for women that have fewer opportunities to learn English. There will be migrants who have lived in the UK for many years and contributed greatly, without having qualified for NHS access and despite working and paying their taxes.
This could particularly affect certain groups. For example, Latin American migrants in the UK have a very high rate of employment – 85% and pay their taxes but some of them don't speak English and find it hard to access the welfare system. As a result, and due to ESOL funding regulation, access to ESOL is very limited for people who are in work. Some women will prefer to ensure abuse and violence putting their lives at risk rather than losing access to services for their children. Victims of domestic violence whose route to permanent residence (and therefore NHS access) is reliant on their sponsorship of an abusive partner or family member will be particularly vulnerable.
As a coalition of organisations with daily contact with the Latin American community, we also know that there are many people whose visa applications processes are being delayed by the Home Office. It would be unfair for these people to have to pay for health services through their tax contributions and also have to pay the extra fee for migrants because the Home Office is delayed.
In addition, it is very probable that undocumented migrants will be reluctant to register their details in order to pay for the proposed fee, which will leave them outside of the NHS provision for years. In addition, those who are able to secure their status after 20 years (10 for undocumented children) will probably require greater use of NHS resources.
As they represent an additional obstacle at the moment of accessing health services,

the proposed changes will encourage self-medication and informal provision of health services, which may lead to the deterioration of patients' physical and mental health, and in consequence, further use of NHS resources. These factors represent a serious threat not only for patients, but also for the population as a whole.

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

Response:

The principle of exempting those with a long-term relationship from the UK from charges is a sound one, but the proposals for evidencing this relationship are highly discriminatory.

Some people will have been long-term residents of the UK without having paid the required 7 years NI contributions, for reasons including education, disability and caring responsibilities. To base entitlement on NI contributions will discriminate against some groups, particularly BME groups, young people, women and disabled people. This is a concerning precedent for NHS access, which if extended to the resident population would undermine the current purpose and function of the NHS, redefining it as a contribution-based health system.

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

Response:

No.

Direct contribution to the cost of healthcare, in practice means double charging migrants. Migrants who come to live in the UK for an extended period of time (more than six months) already contribute to the NHS through their regular taxation (VAT, income tax and National Insurance Contributions). They also contribute to revenue through their visa fees prior to entering the UK and, in the case of students; they also contribute through the payment of their overseas fees, while their access to work is also regulated.

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

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

b) Health insurance (for NHS treatment)

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

Response:

c) The consultation documentation does not provide sufficient evidence to indicate that a greater financial contribution from resident non-EEA migrants is needed.

A better initial focus would be on recouping costs from other EEA nations, for the treatment of their citizens, as this is a far more straight-forward matter of implementation that does not require a change in law. Following successful implementation of these laws, the question of non-EEA migrant contribution could be re-considered.

Despite disagreeing with this, if there is no option, the health levy appears the more efficient as it would in theory reduce the administrative burden of the current charging regime (which would only be replicated by a system reliant on claiming back charges from health insurance).

For genuinely short-term visitors (less than six months), health insurance may be appropriate.

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

a) £200 per year

b) £500 per year

c) Other amount (please specify)?

Response:

c) A health levy should not be introduced. However, if a levy is introduced, it should be no higher than £200. For a family of 4, this would represent a cost of £800 pounds. Ability to pay for a health levy will therefore become an additional requirement to the already high costs of visa application processes. Raising barriers to those trying to secure their status may lead to an increase of the undocumented sector.

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

a) Fixed
b) Varied

Response:

a) Fixed

Any levy should be fixed. Variation based on age is likely to be discriminatory and affect certain groups with protected characteristics such as older migrants. It also opens up the possibility of discriminating against other groups such as disabled people, pregnant

women and women in general.

Question 10: Should some or all categories of temporary migrant (Visa Tiers) be granted the flexibility to opt out of paying the migrant levy, for example where they hold medical insurance for privately provided healthcare?

(Yes / No / Don't know)

Response:

No.

While migrants may not wish to pay for both health insurance and a levy, there are significant risks associated with introducing a two-track system of a levy and health insurance. Many travel insurance policies currently offered do not cover a full range of services, for example, maternity care; and it is likely that the same gaps will exist in private health insurance policies held by temporary migrants.

There will also be an additional administrative impact on NHS services to have an insurance system in place parallel to the levy system. It seems likely that any administration of eligibility through private insurance will be in practice very similar to the charging rules, if patients are charged and then recoup their costs later. The alternative, involving NHS administrators in recouping costs directly from healthcare providers, is likely to be even more burdensome.

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

(Yes / No / Don't know)

Response:

No.

If a levy is charged, it should be required only as part of initial applications to enter the UK. It is discriminatory to expect it to be paid as part of an application to extend leave. Migrants applying to extend leave will have been living in the UK for a considerable period, during which time they have contributed to the NHS through everyday taxation. In addition, applying for extension of leave clearly indicates that the migrant does not consider his/her stay 'temporary', but considers the UK his/her country of residence. It is only reasonable that s/he can access healthcare as a UK resident at this point.

It would also be unfair and unreasonable to implement any levy which would affect migrants who arrived in the UK under different entry rules, mid-way through their journey to permanent residence.

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

Response:

No. The current system of charging for secondary care is not successful in its aims of recouping the costs of treating Overseas Visitors and in fact leads to greater costs on the NHS by encouraging migrants to avoid seeking healthcare until they are seriously ill. It is not cost-effective and creates significant costs in administration. It also raises public health concerns.

As observed in the *2012 Review of overseas visitors charging policy*, the majority of migrants currently affected by NHS charges are people living in the UK without the required immigration clearance or documentation. This includes refused asylum seekers and visa overstayers. Many of this group will do some form of work but only very few would be able to afford to pay the charges for healthcare they access. In reality, the charging regime means that they are likely to avoid accessing healthcare until they are seriously ill. This has impact for their health, increasing the likelihood of need to access more costly treatment in future (which they have a right to access but the charges for which they will not be able to pay). In the case of communicable disease, this will also have a major impact on the health of the community.

If it were possible to identify genuine 'Health Tourists' – those who come to the UK on a short-term basis for the express purpose of receiving free NHS care – it would be acceptable to charge them directly for the services they use. However, the current system captures a much broader group of patients, with both financial and health costs to the NHS.

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

Response:

No.

The current approach of charging irregular migrants for care should not be continued because it does not work well. Irregular migrants are a very vulnerable group who cannot afford to pay for their healthcare. Charging them is extremely costly from the perspective of individual health and public health, as chargeable migrants avoid seeking treatment until they are seriously ill. Any treatment they need at this point will be provided but will not be recouped. It would be much more cost-effective to reduce barriers to healthcare access for this group.

The practice of charging vulnerable irregular migrants for their healthcare runs completely contrary to the overarching principles set out at the beginning of this document. It is against human rights; it denies healthcare to those in need; it is unfair (these are members of our society who contribute financially and otherwise, without any healthcare entitlement); it is neither efficient nor workable from a cost perspective; and it actively increases health inequalities in our communities, increasing public health risks.

Question 14: Do you agree with the proposed changes to individual exemptions? Are any further specific exemptions required?

Response:

CLAUK agrees with the exemptions and welcomes the continued exemptions for services with a public health function. Maternity services should be exempted on the same basis.

There is also a need for further exemptions for the following groups:

- People who have been granted humanitarian protection or discretionary leave
- Children

What services should we charge for?

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

Response:

CLAUK supports the right of any person to register with a GP on the basis of ordinary residency, as it currently operates.

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

(Yes / No / Don't know)

Response:

No.

Maintaining universal access to primary care is vital to both individual and public health.

The consultation question asks about 'temporary migrants', but this is a deceptive term for a broad group of people who are living in the UK for up to 5 years before being considered 'ordinarily resident'. Extending charging to primary care will also affect the many people living in the UK on a long-term basis who have irregular migration status.

The Economic Argument:
Detering people living in the UK from seeking medical advice, through primary care, will cost the NHS much more when they become ill or develop complications. This is particularly concerning when one considers the importance of early treatment for:

- **Infectious diseases**: Treatment for HIV and TB is free and can prevent onwards

transmission, but this benefit can only be gained if the infection is first diagnosed. Rates of undiagnosed HIV and late diagnosed HIV are 25% and 50% respectively. Primary care is also the site of immunisation programmes, for example for MMR, where 95% herd immunity is needed.

- **Maternity care:** Women who commence antenatal care early in their pregnancy have better maternal and child health outcomes that those commencing care later and reduced need for costly interventions. This also affects children's health.
- **Progressive conditions**: There are considerable efforts to improve the ability of GPs to diagnose cancer early, when it can be treated more effectively. When detected early, diabetes can be treated inexpensively, compared to treating complications arising from unmanaged diabetes. Costs for treating later are far higher than treating at an early stage.
- **Children**: These proposals are likely to put at risk the health of most children in England and Wales by raising public health concerns.

Administrative burden

The current administrative complexity will only be intensified. There is significant existing confusion around eligibility with patients who are entitled access being denied it. In addition, some migrants who are entitled to treatment are likely to avoid attending primary care if they learn from others in their community that some migrants are charged for their treatment. This might certainly be the case for Latin American migrants that already have low rates of access to primary care with 1 in 5 not registered with a GP. These changes will only mean that less Latin Americans will register.

Other aspects of the asylum and immigration system

Access to primary care is essential pin for a number of health-related rules within the asylum and immigration system. For example:

- Victims of domestic violence who are seeking permission to remain in the UK after the breakdown of the relationship with a partner who was sponsoring them must provide proof of the domestic violence. GP are the most important source of evidence. These women are likely to ensure abuse and put theirs and their children lives at risk if they have to pay to access the GP

- Refused asylum seekers applying for Section 4 support on health grounds must be assessed by a doctor (usually a GP). This will close many doors for them as they will be unable to pay for this.

- Asylum seekers asking for an exemption from reporting requirements on health grounds must also provide evidence from their doctor. How will they do this?

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

Response: Charging should not be extended to these services.

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

Response:

No.

Charging for access to emergency treatment is unethical, unworkable and raises serious human rights concerns. Medical staff should not have to consider questions of healthcare eligibility on top of existing pressures to meet competing, urgent needs in a very challenging healthcare environment.

Emergency wards are already overstretched across England and Wales with insufficient staff to provide services. This will only make the situation much worse.

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

Response:

There are no systems of processes which could make charging in A&E workable.

A&E is already an extremely challenging environment from the perspective of patient flow. If the need to authenticate entitlement to NHS access is added into this mix, processes will be delayed and patients will suffer. It is inevitable that in such a high-pressure environment, staff would resort to 'short cut' methods of identifying chargeable patients. This will lead to discrimination based on appearance and will unfairly target BME groups.

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

Response:

No.

Extending charges to care provided by non-NHS providers, including community providers of services, could undermine services which are there specifically to meet the needs of vulnerable people (e.g. outreach services for homeless people and destitute asylum seekers).

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

Response:

It would not be possible to extend charges to non-NHS providers without significantly adding to the administrative burden on those providers and on the NHS as a whole. In addition, this would require sharing of patient information with a much greater range of agencies, which will be extremely difficult to do while respecting data protection principles.

Making the system work in the NHS

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

Response:

Prior to any significant rule changes or structural redesign, there should be an appropriate focus on improving current hospital processes and facilitating access for those communities that are in a situation of exclusion. It is important to establish whether the existing rules can be effectively implemented, prior to an expensive overhaul of the current rules including a very costly new system of establishing entitlement

In particular, the Government should first focus on recouping costs through existing EEA rules, before turning attention to non-EEA nationals.

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

Response:

This is not a workable design proposal. It will be extremely costly, at the same time as undermining the effectiveness of NHS services.

There are serious problems with each of the core components of the new system:

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

As outlined in the consultation document, the only way to implement such a system without discrimination would be to review eligibility and re-register ALL patients. This would be extremely costly to administer. There will also be a health cost. If all residents were required to do this, many patients would choose not to re-register. The result would be that primary care services, including public health interventions, are reaching a smaller proportion of the resident population than at present.

In addition, the only way to ensure compliance with this new system would be to require all patients to show their identity and NHS number prior to accessing treatment, whether at a GP, hospital or emergency setting. This is likely to necessitate the introduction of healthcare ID cards for the whole population. Many residents would consider such a requirement an imposition. It will completely change how people living in the UK experience the NHS. The need to prove identity and therefore entitlement for each patient will also compromise the ability of services to meet health needs quickly and efficiently.

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

We are extremely concerned about any plans to link up sensitive personal data from the NHS with data about immigration status and NI contributions. This would be completely at odds with data protection principles. It will also undermine the relationship of patients with their doctors and discourage many migrants from seeking healthcare, whether they are entitled or not.

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

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

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

To administer a system of NHS registration – and crucially, mass RE-registration of existing patients – it is likely that a new body will have to be set up for this purpose. This will be extremely costly and is likely to cause confusion amongst the general public, considering the number of new bodies very recently established in the NHS reforms.

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

The more providers of services who are able to access eligibility information, the greater the risk from a data protection perspective. To date no evidence has been provided about the scale of the 'problem' of NHS access by non-residents, which is sufficient to outweigh the significant impact that this new system of data-sharing will have on resident's sensitive personal data.

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

A system of incentives to 'maximise' charging can only undermine the relationship between health services and their patients and undermine trust.

We agree that hospitals should not be liable for costs of providing emergency treatment. There should be no charges levied or pursued in this area.

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

While recovery of appropriate charges could be done more efficiently, there is no need to set up a centralised system of re-registration and data-sharing to facilitate this. These resources would be better used to support existing hospital infrastructure around identifying chargeable migrants and recovering costs as appropriate.

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

Response:

The overall proposal of a new system NHS (re)-registration is extremely problematic.

NHS registration should remain with GP practices, in line with the principle of meeting patients' immediately necessary health needs. If someone is required to register with an external agency completely separate from health services, prior to visiting a GP, there is a risk they will not get to see a doctor and these needs will not be met in a timely way.

However, initiating a mass re-registration for all patients at GP surgeries will place an unreasonable administrative burden on these services. From an administrative perspective then, registration in such a system would have to be the responsibility of a dedicated agency (or a new function of an existing agency). This will be extremely costly to set up, and will continue to generate additional administrative costs for GPs, who will still need to check eligibility of all patients at each visit.

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

Response:

There are many significant challenges associated with charging for primary care services, which, considered together, clearly show that such a proposal is unworkable:

- It is entirely unclear how much patients will be charged for primary care access and how these rates will be set – centrally, or by individual GP practices.

- No matter how the system is administered, it will clearly lead to discrimination

against people who appear more 'foreign' and are targeted for eligibility checks.

- The system is unethical, as it may lead to patients being stopped at the point of reception, and never getting to see a doctor. Many undocumented migrants already experience this, despite having primary care entitlement.

- Charging is in conflict with the need to provide immediately necessary treatment where needed, as it is not always obvious to patients or administrative staff whether their health needs meet this test. This can only be established after the patient sees the GP – but if they are chargeable they may never get to the consultation.

- Barriers to primary care access will inevitably lead to greater pressure on A&E, both from people who are seriously ill and from those with less critical health needs which nevertheless must be met.

- Many of those working in the NHS who will be responsible for implementing the system disagree with charging on ethical grounds and will not wish to participate in charging.

- Many working in the NHS who will be responsible for implementing the system will they themselves be subject to the rules.

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

Response:

No.

We do not agree with such a gateway and strongly question whether any such system of sharing sensitive personal data could be set up without contravening data protection principles.

Recovering Healthcare Costs from the European Economic Area (EEA)

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

Response:

No comment.